TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	New London, CT	
5560 ..	New Orleans, LA	0.9140
	Jefferson, LA	
	Orleans, LA	
	Plaquemines, LA	
	St. Bernard, LA	
	St. Charles, LA	
	St. James, LA	
	St. John The Baptist, LA	
	St. Tammany, LA	
5600 ..	New York, NY	1.4338
	Bronx, NY	
	Kings, NY	
	New York, NY	
	Putnam, NY	
	Queens, NY	
	Richmond, NY	
	Rockland, NY	
	Westchester, NY	
5640 ..	Newark, NJ	1.1729
	Essex, NJ	
	Morris, NJ	
	Sussex, NJ	
	Union, NJ	
	Warren, NJ	
5660 ..	Newburgh, NY–PA	1.1035
	Orange, NY	
	Pike, PA	
5720 ..	Norfolk-Virginia Beach-Newport News, VA–NC.	0.8483
	Currituck, NC	
	Chesapeake City, VA	
	Gloucester, VA	
	Hampton City, VA	
	Isle of Wight, VA	
	James City, VA	
	Mathews, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
	York, VA	
5775 ..	Oakland, CA	1.5277
	Alameda, CA	
	Contra Costa, CA	
5790 ..	Ocala, FL	0.9728
	Marion, FL	
5800 ..	Odessa-Midland, TX	0.8951
	Ector, TX	
	Midland, TX	
5880 ..	Oklahoma City, OK	0.8551
	Canadian, OK	
	Cleveland, OK	
	Logan, OK	
	McClain, OK	
	Oklahoma, OK	
	Pottawatomie, OK	
5910 ..	Olympia, WA	1.1023
	Thurston, WA	
5920 ..	Omaha, NE–IA	1.0405
	Pottawattamie, IA	
	Cass, NE	
	Douglas, NE	
	Sarpy, NE	
	Washington, NE	
5945 ..	Orange County, CA	1.1720
	Orange, CA	
5960 ..	Orlando, FL	0.9845
	Lake, FL	
	Orange, FL	
	Osceola, FL	
	Seminole, FL	
5990 ..	Owensboro, KY	0.8199
	Daviess, KY	
6015 ..	Panama City, FL	0.9277
	Bay, FL	
6020 ..	Parkersburg-Marietta, WV–OH.	0.8503
	Washington, OH	
	Wood, WV	
6080 ..	Pensacola, FL	0.8529
	Escambia, FL	
	Santa Rosa, FL	
6120 ..	Peoria-Pekin, IL	0.8201
	Peoria, IL	
	Tazewell, IL	
	Woodford, IL	
6160 ..	Philadelphia, PA–NJ	1.1076
	Burlington, NJ	
	Camden, NJ	
	Gloucester, NJ	
	Salem, NJ	
	Bucks, PA	
	Chester, PA	
	Delaware, PA	
	Montgomery, PA	
	Philadelphia, PA	
6200 ..	Phoenix-Mesa, AZ	0.9420
	Maricopa, AZ	
	Pinal, AZ	
6240 ..	Pine Bluff, AR	0.7777
	Jefferson, AR	
6280 ..	Pittsburgh, PA	0.9478
	Allegheny, PA	
	Beaver, PA	
	Butler, PA	
	Fayette, PA	
	Washington, PA	
	Westmoreland, PA	
6323 ..	Pittsfield, MA	1.0173
	Berkshire, MA	
6340 ..	Pocatello, ID	0.9063
	Bannock, ID	
6360 ..	Ponce, PR	0.4970
	Guayanilla, PR	
	Juana Diaz, PR	
	Penuelas, PR	
	Ponce, PR	
	Villalba, PR	
	Yauco, PR	
6403 ..	Portland, ME	0.9499
	Cumberland, ME	
	Sagadahoc, ME	
	York, ME	
6440 ..	Portland-Vancouver, OR–WA.	1.1087
	Clackamas, OR	
	Columbia, OR	
	Multnomah, OR	
	Washington, OR	
	Yamhill, OR	
	Clark, WA	
6483 ..	Providence-Warwick-Pawtucket, RI.	1.0766
	Bristol, RI	
	Kent, RI	
	Newport, RI	
	Providence, RI	
	Washington, RI	
6520 ..	Provo-Orem, UT	0.9916
	Utah, UT	
6560 ..	Pueblo, CO	0.8922
	Pueblo, CO	
6580 ..	Punta Gorda, FL	0.9620
	Charlotte, FL	
6600 ..	Racine, WI	0.9325
	Racine, WI	
6640 ..	Raleigh-Durham-Chapel Hill, NC.	0.9683
	Chatham, NC	
	Durham, NC	
	Franklin, NC	
	Johnston, NC	
	Orange, NC	
	Wake, NC	
6660 ..	Rapid City, SD	0.8415
	Pennington, SD	
6680 ..	Reading, PA	0.9496
	Berks, PA	
6690 ..	Redding, CA	1.1376
	Shasta, CA	
6720 ..	Reno, NV	1.0781
	Washoe, NV	
6740 ..	Richland-Kennewick-Pasco, WA.	1.1356
	Benton, WA	
	Franklin, WA	
6760 ..	Richmond-Petersburg, VA	0.9569
	Charles City County, VA	
	Chesterfield, VA	
	Colonial Heights City, VA	
	Dinwiddie, VA	
	Goochland, VA	
	Hanover, VA	
	Henrico, VA	
	Hopewell City, VA	
	New Kent, VA	
	Petersburg City, VA	
	Powhatan, VA	
	Prince George, VA	
	Richmond City, VA	
6780 ..	Riverside-San Bernardino, CA	1.1256
	Riverside, CA	
	San Bernardino, CA	
6800 ..	Roanoke, VA	0.7971
	Botetourt, VA	
	Roanoke, VA	
	Roanoke City, VA	
	Salem City, VA	
6820 ..	Rochester, MN	1.1619
	Olmsted, MN	
6840 ..	Rochester, NY	0.9066
	Genesee, NY	
	Livingston, NY	
	Monroe, NY	
	Ontario, NY	
	Orleans, NY	
	Wayne, NY	
6880 ..	Rockford, IL	0.8885
	Boone, IL	
	Ogle, IL	
	Winnebago, IL	
6895 ..	Rocky Mount, NC	0.8837

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
	Edgecombe, NC	
	Nash, NC	
6920 ..	Sacramento, CA	1.2473
	El Dorado, CA	
	Placer, CA	
	Sacramento, CA	
6960 ..	Saginaw-Bay City-Midland, MI.	0.9365
	Bay, MI	
	Midland, MI	
	Saginaw, MI	
6980 ..	St. Cloud, MN	0.9525
	Benton, MN	
	Stearns, MN	
7000 ..	St. Joseph, MO	0.9048
	Andrews, MO	
	Buchanan, MO	
7040 ..	St. Louis, MO–IL	0.8943
	Clinton, IL	
	Jersey, IL	
	Madison, IL	
	Monroe, IL	
	St. Clair, IL	
	Franklin, MO	
	Jefferson, MO	
	Lincoln, MO	
	St. Charles, MO	
	St. Louis, MO	
	St. Louis City, MO	
	Warren, MO	
	Sullivan City, MO	
7080 ..	Salem, OR	1.0065
	Marion, OR	
	Polk, OR	
7120 ..	Salinas, CA	1.4900
	Monterey, CA	
7160 ..	Salt Lake City-Ogden, UT	0.9919
	Davis, UT	
	Salt Lake, UT	
	Weber, UT	
7200 ..	San Angelo, TX	0.7938
	Tom Green, TX	
7240 ..	San Antonio, TX	0.8429
	Bexar, TX	
	Comal, TX	
	Guadalupe, TX	
	Wilson, TX	
7320 ..	San Diego, CA	1.2100
	San Diego, CA	
7360 ..	San Francisco, CA	1.4287
	Marin, CA	
	San Francisco, CA	
	San Mateo, CA	
7400 ..	San Jose, CA	1.3848
	Santa Clara, CA	
7440 ..	San Juan-Bayamon, PR	0.4698
	Aguas Buenas, PR	
	Barceloneta, PR	
	Bayamon, PR	
	Canovanas, PR	
	Carolina, PR	
	Catano, PR	
	Ceiba, PR	
	Comerio, PR	
	Corozal, PR	
	Dorado, PR	
	Fajardo, PR	
	Florida, PR	
	Guaynabo, PR	
	Humacao, PR	
	Juncos, PR	
	Los Piedras, PR	
	Loiza, PR	
	Luguillo, PR	
	Manati, PR	
	Morovis, PR	
	Naguabo, PR	
	Naranjito, PR	
	Rio Grande, PR	
	San Juan, PR	
	Toa Alta, PR	
	Toa Baja, PR	
	Trujillo Alto, PR	
	Vega Alta, PR	
	Vega Baja, PR	
	Yabucoa, PR	
7460 ..	San Luis Obispo-Atascadero-PasoRobles, CA.	1.0593
	San Luis Obispo, CA	
7480 ..	Santa Barbara-Santa Maria-Lompoc, CA.	1.0939
	Santa Barbara, CA	
7485 ..	Santa Cruz-Watsonville, CA.	1.4091
	Santa Cruz, CA	
7490 ..	Santa Fe, NM	1.0511
	Los Alamos, NM	
	Santa Fe, NM	
7500 ..	Santa Rosa, CA	1.3172
	Sonoma, CA	
7510 ..	Sarasota-Bradenton, FL	1.0022
	Manatee, FL	
	Sarasota, FL	
7520 ..	Savannah, GA	0.9995
	Bryan, GA	
	Chatham, GA	
	Effingham, GA	
7560 ..	Scranton-Wilkes-Barre-Hazleton, PA.	0.8442
	Columbia, PA	
	Lackawanna, PA	
	Luzerne, PA	
	Wyoming, PA	
7600 ..	Seattle-Bellevue-Everett, WA.	1.1376
	Island, WA	
	King, WA	
	Snohomish, WA	
7610 ..	Sharon, PA	0.8374
	Mercer, PA	
7620 ..	Sheboygan, WI	0.8299
	Sheboygan, WI	
7640 ..	Sherman-Denison, TX	0.9439
	Grayson, TX	
7680 ..	Shreveport-Bossier City, LA.	0.9126
	Bossier, LA	
	Caddo, LA	
	Webster, LA	
7720 ..	Sioux City, IA–NE	0.8552
	Woodbury, IA	
	Dakota, NE	
7760 ..	Sioux Falls, SD	0.8813
	Lincoln, SD	
	Minnehaha, SD	
7800 ..	South Bend, IN	0.9732
	St. Joseph, IN	
7840 ..	Spokane, WA	1.0898
	Spokane, WA	
7880 ..	Springfield, IL	0.8710
	Menard, IL	
	Sangamon, IL	
7920 ..	Springfield, MO	0.8062
	Christian, MO	
	Greene, MO	
	Webster, MO	
8003 ..	Springfield, MA	1.0488
	Hampden, MA	
	Hampshire, MA	
8050 ..	State College, PA	0.9212
	Centre, PA	
8080 ..	Steubenville-Weirton, OH–WV.	0.8716
	Jefferson, OH	
	Brooke, WV	
	Hancock, WV	
8120 ..	Stockton-Lodi, CA	1.0571
	San Joaquin, CA	
8140 ..	Sumter, SC	0.8335
	Sumter, SC	
8160 ..	Syracuse, NY	0.9310
	Cayuga, NY	
	Madison, NY	
	Onondaga, NY	
	Oswego, NY	
8200 ..	Tacoma, WA	1.1583
	Pierce, WA	
8240 ..	Tallahassee, FL	0.8529
	Gadsden, FL	
	Leon, FL	
8280 ..	Tampa-St. Petersburg-Clearwater, FL.	0.9136
	Hernando, FL	
	Hillsborough, FL	
	Pasco, FL	
	Pinellas, FL	
8320 ..	Terre Haute, IN	0.8614
	Clay, IN	
	Vermillion, IN	
	Vigo, IN	
8360 ..	Texarkana, AR–TX	0.8101
	Miller, AR	
	Bowie, TX	
8400 ..	Toledo, OH	0.9764
	Fulton, OH	
	Lucas, OH	
	Wood, OH	
8440 ..	Topeka, KS	0.9440
	Shawnee, KS	
8480 ..	Trenton, NJ	1.0180
	Mercer, NJ	
8520 ..	Tucson, AZ	0.8846
	Pima, AZ	
8560 ..	Tulsa, OK	0.8181
	Creek, OK	
	Osage, OK	
	Rogers, OK	
	Tulsa, OK	
	Wagoner, OK	
8600 ..	Tuscaloosa, AL	0.8104
	Tuscaloosa, AL	
8640 ..	Tyler, TX	0.9499
	Smith, TX	
8680 ..	Utica-Rome, NY	0.8370
	Herkimer, NY	
	Oneida, NY	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
8720 ..	Vallejo-Fairfield-Napa, CA	1.3503
	Napa, CA	
	Solano, CA	
8735 ..	Ventura, CA	1.1603
	Ventura, CA	
8750 ..	Victoria, TX	0.8476
	Victoria, TX	
8760 ..	Vineland-Millville-Bridgeton, NJ.	1.0640
	Cumberland, NJ	
8780 ..	Visalia-Tulare-Porterville, CA.	1.0533
	Tulare, CA	
8800 ..	Waco, TX	0.8099
	McLennan, TX	
8840 ..	Washington, DC–MD–VA–WV.	1.1088
	District of Columbia, DC	
	Calvert, MD	
	Charles, MD	
	Frederick, MD	
	Montgomery, MD	
	Prince Georges, MD	
	Alexandria City, VA	
	Arlington, VA	
	Clarke, VA	
	Culpepper, VA	
	Fairfax, VA	
	Fairfax City, VA	
	Falls Church City, VA	
	Fauquier, VA	
	Fredericksburg City, VA	
	King George, VA	
	Loudoun, VA	
	Manassas City, VA	
	Manassas Park City, VA	
	Prince William, VA	
	Spotsylvania, VA	
	Stafford, VA	
	Warren, VA	
	Berkeley, WV	
	Jefferson, WV	
8920 ..	Waterloo-Cedar Falls, IA	0.8597
	BlackHawk, IA	
8940 ..	Wausau, WI	0.9556
	Marathon, WI	
8960 ..	West Palm Beach-Boca, FL	1.0130
	Palm Beach, FL	
9000 ..	Wheeling, OH–WV	0.7662
	Belmont, OH	
	Marshall, WV	
	Ohio, WV	
9040 ..	Wichita, KS	0.9559
	Butler, KS	
	Harvey, KS	
	Sedgwick, KS	
9080 ..	Wichita Falls, TX	0.7743
	Archer, TX	
	Wichita, TX	
9140 ..	Williamsport, PA	0.8472
	Lycoming, PA	
9160 ..	Wilmington-Newark, DE–MD.	1.1000
	New Castle, DE	
	Cecil, MD	
9200 ..	Wilmington, NC	0.9818
	New Hanover, NC	
	Brunswick, NC	

TABLE 3E.—WAGE INDEX URBAN AREAS—Continued

MSA	Urban area (Constituent counties or county equivalents)	Wage index
9260 ..	Yakima, WA	1.0331
	Yakima, WA	
9270 ..	Yolo, CA	0.9833
	Yolo, CA	
9280 ..	York, PA	0.9255
	York, PA	
9320 ..	Youngstown-Warren, OH	1.0025
	Columbiana, OH	
	Mahoning, OH	
	Trumbull, OH	
9340 ..	Yuba City, CA	1.0787
	Sutter, CA	
	Yuba, CA	
9360 ..	Yuma, AZ	1.0040
	Yuma, AZ	

TABLE 4E.—WAGE INDEX FOR RURAL AREAS

Nonurban area	Wage Index
Alabama	0.7467
Alaska	1.2175
Arizona	0.8625
Arkansas	0.7317
California	1.0066
Colorado	0.8915
Connecticut	1.2559
Delaware	0.9240
Florida	0.9089
Georgia	0.8176
Guam	
Hawaii	1.0853
Idaho	0.8707
Illinois	0.8122
Indiana	0.8493
Iowa	0.7976
Kansas	0.7513
Kentucky	0.8127
Louisiana	0.7456
Maine	0.8679
Maryland	0.8730
Massachusetts	1.1499
Michigan	0.8896
Minnesota	0.8743
Mississippi	0.7374
Missouri	0.7802
Montana	0.8479
Nebraska	0.8024
Nevada	0.9197
New Hampshire	0.9827
New Jersey [1]	
New Mexico	0.8472
New York	0.8604
North Carolina	0.8378
North Dakota	0.7662
Ohio	0.8746
Oklahoma	0.7332
Oregon	0.9966
Pennsylvania	0.8559
Puerto Rico	0.4299
Rhode Island [1]	
South Carolina	0.8353
South Dakota	0.7625
Tennessee	0.7738
Texas	0.7545
Utah	0.8998

TABLE 4E.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban area	Wage Index
Vermont	0.9518
Virginia	0.7991
Virgin Islands	
Washington	1.0548
West Virginia	0.8116
Wisconsin	0.8838
Wyoming	0.8955

[1] All counties within the State are classified urban.

The resulting wage-adjusted labor-related portion is added to the nonlabor related portion, resulting in a wage-adjusted payment. The following example illustrates how a Medicare fiscal intermediary would calculate the Adjusted Facility Federal prospective payment for inpatient rehabilitation facility services with a hypothetical Federal prospective payment of $10,000 for services provided in the rehabilitation facility located in Heartland, USA. The rehabilitation wage index value for facilities located in Heartland, USA is 1.0234. The labor-related portion (71.301 percent) of the Federal prospective payment is $7130.10=($10,000*71.301 percent), and the nonlabor related portion (28.699 percent) of the Federal prospective payment is $2869.90=($10,000*28.699 percent). Therefore, the wage-adjusted payment calculation, rounded to the nearest dollar is as follows:

$10,167=($7130.10*1.0234) + $2,869.90

2. General Specifications to Determine Other Adjustments

As indicated earlier, section 1886(j)(3)(A)(v) of the Act confers broad authority on the Secretary to adjust prospective payments ''by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities''. To determine whether other payment adjustments are warranted for the IRF prospective payment system, we conducted extensive regression analysis of the relationship between IRF costs (including both operating and capital costs per case) and several factors that may affect costs. The appropriateness of potential payment adjustments are based on both cost effects estimated by regression analysis and other factors, including simulated payments that we discuss in section VIII.B.2. of this preamble.

Our analyses included 624 facilities for which cost and case-mix data were available. We estimated costs for each case by multiplying facility specific,

cost-center specific cost-to-charge ratios by charges. Cost-to-charge ratios were obtained from FYs 1995, 1996, and/or 1997 cost report data and charges were obtained from the calendar years 1996 and 1997 Medicare claims data. The cost per case is calculated by summing all costs and dividing by the number of equivalent full cases. When we had cost per case data for both years, the number of cases and total costs are combined for both years. We accounted for the difference in the year by adjusting the 1996 cost per case by the case-weighted average change in cost per case between 1996 and 1997. Using the data from both years should provide more stability in the payment adjustments than would using data for a single year. When data for only one year are available, we use the costs and number of equivalent cases for that year.

Multivariate regression analysis is a standard way to examine facility cost variation and analyze potential payment adjustments. We looked at two standard models: (1) Fully specified explanatory models to examine the impact of all relevant factors that might potentially affect facility cost per case; and (2) payment models that examine the impacts of those factors specifically used to determine payment rates. The general specification for the multivariate regression is that the estimated average cost per case (the dependent variable) at the facility can be explained or predicted by several independent variables, including the case-mix index, the wage index for the facility, and a vector of additional explanatory variables that affect a facility's cost per case, such as its teaching program or the proportion of low-income patients. The case-mix index is the average of the CMG weights derived by the hospital-specific relative value method for each facility. Transfer cases are given a partial weight based on the ratio of the length of stay for the transfer to the average length of stay for nontransfer cases. Using the regression coefficients, we then simulated payments and calculated payment-to-cost ratios for different classes of hospitals, for specific combinations of payment policies.

We use payment variables from the hospital inpatient prospective payment system, including disproportionate share patient percentage, both capital and operating teaching variables (resident-to-average daily census and resident-to-bed ratios, respectively) as well as the teaching variable (resident-to-adjusted average daily census ratio) used in the analyses for the hospital outpatient prospective payment system, and variables to account for location in a rural or large urban area. A discussion of the major payment variables and our findings appears below.

3. Adjustments for Rural Location

We examined costs per case for both large urban and rural facilities. In the regression models, both explanatory and payment, the variable for rural facilities was positive and significant ($p<0.05$). The standardized cost per case for rural hospitals is 15 percent higher than the national average. On average, rural facilities tend to have fewer cases, a longer length of stay, and a higher average cost per case. The difference in costs becomes more evident when the average cost per case is standardized for the case-mix index and the wage index. In the regression models, large urban facilities were not significantly different from other urban facilities. We propose, under § 412.624(e)(3), to adjust for rural facilities by multiplying the payment by 1.1589. This adjustment was determined by using the coefficients derived from the regressions.

4. Adjustments for Indirect Teaching Costs

Facilities with major teaching programs tend to be located in large urban areas and have more cases, a higher case-mix and a higher proportion of low-income patients. We found that when only the payment variables that might warrant an adjustment (that is, DSH or rural/urban status, rather than for-profit/not for profit) under the prospective payment system are used in the regression models, the indirect teaching cost variable is not significant. We looked at different specifications for the teaching variable. We used a resident-to-average daily census ratio and a resident-to-bed ratio that we based on the estimated number of residents assigned to the inpatient area of the rehabilitation facility. We also used a resident-to-adjusted average daily census ratio based on the total number of residents at the hospital complex and outpatient as well as inpatient volume. We also looked for a teaching threshold. In all our payment regressions, the teaching variable was not significant. Therefore, we are not proposing an adjustment for indirect teaching costs.

5. Adjustments for Disproportionate Share of Low-Income Patients

We assessed the appropriateness of adjustments for facilities serving a disproportionate share of low income patients. We limited our analysis to the effects of serving low-income patients on costs per case, rather than a subsidy for uncompensated care.

We evaluated a facility-level adjustment that takes into account both the percentage of Medicare patients who are on Supplemental Security Income and the percentage of Medicaid patients who are not entitled to Medicare. As a facility's percentage of low income patients increases, there is an incremental increase in the facility's cost. This suggests that additional payments are appropriate. We propose to use the same measure of disproportionate patient percentage currently used for the acute care hospital inpatient prospective payment system. Payments for each facility would be adjusted to reflect the facility's disproportionate share percentage.

Section 4403(b) of the BBA requires HCFA to develop a Report to the Congress containing a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Act. In determining the formula, the Secretary must:

- Establish a single threshold for costs incurred by hospitals serving low-income patients.
- Consider the costs incurred in furnishing hospital services to individuals who are entitled to benefits under Part A of Medicare and who receive Supplemental Security Income benefits under Title XVI.
- Consider the costs incurred in furnishing hospital services to individuals who receive medical assistance under the State plan under the Medicare program and are not entitled to benefits under Part A of Medicare.

Further, MedPAC recommends including the costs of uncompensated care in calculating low-income shares and using the same formula to distribute payments to all facilities covered by prospective payments. In light of HCFA's current study of a new payment formula for determining adjustments for hospitals serving low income patients and MedPAC's recommendations, we will consider these study results and other information as it becomes available and potentially refine the DSH adjustment in the future so that we ensure that facilities are paid in the most consistent and equitable manner possible. At this time, we propose, under § 412.624(e)(2), to adjust each rehabilitation facility payment by the following formula to account for the cost of furnishing care to low income patients: ((.0001+DSH) raised to the power of .0905)/(.0001 raised to the power of .0905));

$$\text{Where DSH} = \frac{\text{Medicare SSI Days}}{\text{Total Medicare Days}} + \frac{\text{Medicaid, Non-Medicare Days}}{\text{Total Days}}$$

6. Adjustments for Alaska and Hawaii

Section 1886(j)(4)(B) provides that the Secretary is authorized but not required to take into account the unique circumstances of IRFs located in Alaska and Hawaii. There are currently three IRFs in Hawaii and one in Alaska. However, we have cost and case-mix data for only one of the facilities in Hawaii (982 cases) and the facility in Alaska (117 cases). In the absence of a cost-of-living adjustment, our simulations indicate that the facility in Hawaii may profit and the facility in Alaska may experience a loss. Due to the small number of cases, analyses of the simulation results are inconclusive regarding whether a cost-of-living adjustment would improve payment equity for these facilities. Therefore, we are not proposing an adjustment for rehabilitation facilities located in Alaska and Hawaii.

7. Adjustments for Cost Outliers

Section 1886(j)(4) of the Act specifies that the Secretary is authorized, but not required, to provide for additional payments for outlier cases. Further, section 1886(j)(4)(A)(iii) of the Act specifies that the total amount of the additional payments cannot be projected to exceed 5 percent of the total payments in a given year. Providing additional payments for costs that are beyond facilities' control can strongly improve the accuracy of the IRF prospective payment system in determining resource costs at the patient and facility level. In general, outlier payments reduce the financial risk which would otherwise be substantial because of the relatively small size of many rehabilitation facilities. These additional payments reduce the financial losses caused by treating patients who require more costly care and, therefore, will reduce the incentives to under serve these patients.

We considered various outlier policy options. Specifically, we examined outlier policies using 3, 4, and 5 percent of the total estimated payments. In order to determine the most appropriate outlier policy, we analyzed the extent to which the various options reduce financial risk, reduce incentives to underserve costly beneficiaries, and improve the overall fairness of the system. We believe an outlier policy of 3 percent will allow us to achieve a balance of the above stated goals. Additional increments of outlier payments reduce risk by successively smaller amounts. Further, additional amounts of outlier payments are funded by prospectively reducing the non-outlier payment rates in a budget neutral manner. Therefore, we propose an outlier policy of 3 percent of total estimated payments because we believe this option optimizes the extent to which we can protect vulnerable facilities, while still providing adequate payment for all other cases.

We propose, under § 412.624(e)(4), to make outlier payments for discharges whose estimated cost exceeds an adjusted threshold amount ($7,066 multiplied by the facility's adjustments) plus the adjusted CMG payment. Both the loss threshold and the CMG payment amount are adjusted for wages, rural location, and disproportionate share. The estimated cost of a case will be calculated by multiplying an overall facility-specific cost-to-charge ratio by the charge. Based on analysis of payment-to-cost ratios for outlier cases, and consistent with the marginal cost factor used under section 1886(d) of the Act, we propose to pay outlier cases 80 percent of the difference between the estimated cost of the case and the outlier threshold (the sum of the CMG payment and the loss amount of $7,066, as adjusted). The outlier threshold was calculated by simulating aggregate payments with and without an outlier policy, and applying an iterative process to determine a threshold that would result in outlier payments being equal to 3 percent of total payments under the simulation.

E. Calculation of the Budget Neutral Conversion Factor Minus Two Percent

1. Overview of Development of the Budget Neutral Conversion Factor

Section 1886(j)(3)(B) of the Act and proposed § 412.624(d) of the regulations specify that, for prospective payment units during FYs 2001 and 2002, the amount of total payments, including any payment adjustments under sections 1886(j)(4) and (6) of the Act, shall be projected to equal 98 percent of the amount of payments that would have been made during these fiscal years for operating and capital costs of rehabilitation facilities had section 1886(j) not been enacted.

We propose, under § 412.624(c)(1), to calculate the budget neutral conversion factor using the following steps:

Step 1—Update the latest cost report data to the midpoint of the year 2001.

Step 2—Estimate total payments under the current payment system.

Step 3—Calculate the average weighted payment per discharge amount under the current payment system.

Step 4—Estimate new payments under the proposed payment system without a budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor.

2. Steps for Developing the Budget Neutral Conversion Minus 2 Percent

- Data Sources

The data sources that we propose under § 412.624(a)(1) to construct the budget neutral adjustment factor include the cost report data from FYs 1995, 1996, and 1997, a list obtained from the fiscal intermediaries of facility-specific target amounts applicable for providers that applied to rebase their target amount in fiscal year 1998, and calendar year 1996 and 1997 Medicare claims with corresponding UDSmr or COS data. We used data from 508 facilities to calculate the budget neutral conversion factor. These facilities represent those providers for which we had cost report data available from FYs 1995, 1996, and 1997. We used the 3 years cost report data to trend the data to the midpoint of the year 2001 based on the facilities' historical relationship of costs and target amounts. The FY 1995 cost report data was used to determine the update to be used for FY 1999, the FY 1996 cost report data was used to determine the update to be used for FY 2000, and the FY 1997 cost report data was used to determine the update to be used for FY 2001. We were unable to calculate payment under the current payment system for some inpatient rehabilitation facilities because cost report data were unavailable. We will attempt to obtain the most recent payment amounts for these facilities through their Medicare fiscal intermediary and we will consider using this data to construct the payment rates for the final rule. We will also examine the extent to which certain facilities, such as new facilities, are not included in the construction of the budget neutral conversion factor and consider the appropriateness of an adjustment to better reflect total estimated payments for IRFs.

Step 1—Update the latest cost report data to the midpoint of the year 2001. Section 1886(j)(3)(A)(i) of the Act and proposed § 412.624(b) of the regulations

specify that the per-payment-unit amount is to be updated to the midpoint of the fiscal year 2000, using the weighted average of the applicable percentage increases provided under Section 1886(b)(3)(B)(ii) of the Act. The statute allows us more discretion in determining an appropriate methodology to update from the year 2000 to 2001. We propose, under § 412.624(c)(2), to update from the midpoint of the year 2000 to the midpoint of the year 2001 using the same methodology provided under Section 1886(b)(3)(B)(ii). We determine the appropriate update factor for each facility by using one of the four methodologies described below:

- For facilities with costs that equal or exceed their target amounts by 10 percent or more for the most recent cost reporting period for which information is available, the update factor is the market basket percentage increase; or
- For facilities that exceed their target by less than 10 percent, the update factor would be equal to the market basket minus .25 percentage points for each percentage point by which operating costs are less than 10 percent over the target (but in no case less than 0); or
- For facilities that are at or below their target but exceed two-thirds of the target amount, the update factor is the market basket minus 2.5 percentage points (but in no case less than 0); or
- For facilities that do not exceed two-thirds of their target amount, the update factor is 0 percent.

Step 2—Estimate total payments under the current payment system.

Operating payments are calculated using the following methodology:

Step 2a—We determine the facility-specific target amount, subject to the applicable cap on the target amounts for rehabilitation facilities. There are two national caps on the target amounts for rehabilitation facilities. We used the cap amounts published in the July 30, 1999 **Federal Register**. For older facilities certified before October 1, 1997, the applicable cap amount for FY 2000 is $14,654 for the labor-related share adjusted by the appropriate geographic wage index and added to $4,169 for the nonlabor-related share. For newer facilities certified on or after October 1, 1997, the cap amount applicable for FY 2000 is $12,574 for the labor-related share adjusted by the appropriate geographic wage index and added to $4,999 for the nonlabor-related share. These target amounts are then inflated to the midpoint of the year 2001 by applying the excluded hospital operating market basket.

Step 2b—We calculate the lower of the results of step 2a.

- The facility-specific target amount (including application of the cap) times the Medicare discharges (the ceiling) or;
- The facility average operating cost per case times Medicare discharges. Payment for operating costs are determined by using one of the following methods:
- For facilities whose operating costs are lower than or equal to the ceiling, payment would be the lower of either the operating cost plus 15 percent of the difference between the operating cost and the ceiling or the operating costs plus 2 percent of the ceiling; or
- For facilities whose operating costs are more than 110 percent of the ceiling, payment would be the lower of either the ceiling multiplied by 1.10 or half of the difference between the 110 percent of the ceiling and the operating costs.
- For facilities whose operating costs are greater than the ceiling but less than 110 percent of the ceiling, payment would be the ceiling.

Step 2c—After operating payments are computed, we determine capital payments. Section 4412 of the BBA amended section 1886(g) of the Act by reducing capital payments that would otherwise be made for rehabilitation facilities. Payments for capital costs are made on a reasonable cost basis. The BBA mandated the reduction of capital payments by 15 percent. Therefore, we reduce capital payments for inpatient rehabilitation facilities or units by multiplying the costs by .85.

Step 2d—The next step in determining total payments under the current payment system is to add operating and capital payments. Section 1886(j)(1)(A) of the Act specifies that the IRF prospective payment system will include both operating and capital costs. Once appropriate payments for operating costs are determined (including bonus and penalty payments as appropriate), and after reductions are made for capital payments, we would add the operating costs and the reduced capital costs together.

Step 2e—The statute provides for the Secretary to adjust the rates so that the amount of total payments under this section are projected to equal 98 percent of the payments that would have been paid under this section in the absence of this new payment methodology. Payments made for cost reporting periods beginning on or after the implementation of this prospective payment system through FY 2002 are based on both the facility-specific payment and the Federal prospective payment that we propose in this regulation. Therefore under proposed § 412.624(d)(2), we reduce total estimated payments calculated under the current payment system to ensure that the 98 percent budget neutrality provision is applicable to all payments. In addition, total estimated payments are adjusted to reflect the estimated proportion of additional outlier payments, under proposed § 412.624(d)(1) and for coding and classification changes under proposed § 412.624(d)(3). These payments are the proposed numerator of the equation used to calculate the budget neutral adjustment.

Step 3—Calculate the average weighted payment per discharge amount under the current payment system. Once total payments are calculated under the current payment system, an average per discharge payment amount weighted by the number of Medicare discharges under the current payment system can be calculated. This is done by first determining the average payment per discharge amount under the current payment system for each facility. Cost report data are used to calculate each facility's average payment per discharge by dividing the number of discharges into the total payments. The next step is to determine the weighted average per discharge payment amount. To calculate this amount, we multiply the number of discharges from the Medicare bills (with corresponding UDSmr/COS data) by each facility's average payment per discharge amount. We then sum the amounts for all facilities and divide by the total number of discharges from the Medicare bills (with corresponding UDSmr/COS data) to derive an average payment per discharge amount that is weighted by the number of Medicare discharges.

Step 4—Estimate payments under the proposed payment system without a budget neutral adjustment. Payments under the proposed payment system are then simulated without a budget neutral adjustment. To do this, we multiply the following: each facility's case-mix index, the number of discharges from the Medicare bills (with corresponding UDSmr/COS data), the appropriate wage index, the rural adjustment (if applicable), an appropriate disproportionate share adjustment, and the weighted average per discharge payment amount computed in Step 3. Total payments for each facility are then added together. This total is the denominator in the calculation of the budget neutral adjustment.

Step 5—Determine the budget neutral conversion factor. The denominator of the budget neutral adjustment equation is the total estimated payments for the

proposed prospective payment system without a budget neutral adjustment (the total amount calculated in Step 4). The budget neutral adjustment is calculated by dividing total reduced payments under the current payment system (the total amount calculated in Step 2) by estimated payments for the proposed prospective payment system. The resulting budget neutral adjustment is then multiplied by the average weighted per discharge payment amount under the current payment system to derive the budget neutral conversion factor.

Because we do not have UDSmr and COS data for all rehabilitation facilities, for the final rule we will further analyze the extent to which the data used to construct the budget neutral conversion factor accurately reflect the relationship between case-mix and cost. We are considering the use of weighted averages to more fully account for those types of facilities that may be under-represented with the given data.

Once the budget neutral conversion factor is calculated, the factor is further adjusted to include a behavioral offset. As previously stated, to calculate the budget neutral conversion factor, we had to estimate what would have been paid under the current payment system. However, due to the incentives for premature discharge inherent in the new payment system, we expect that differences in the utilization of these services might result. In the case of the proposed payment system, discharges to other settings of care may take place earlier than under the current payment system. This would result in lower payments under the current payment system for this care, which must be taken into account when computing budget neutral payment rates. Accounting for this effect through an adjustment is commonly known as a behavioral offset. The budget neutral conversion factor with a behavioral offset is $6,024. This represents a .64 percent (that is, sixty four hundredths of one percent) reduction in the budget neutral conversion factor otherwise calculated under the methodology described in the preceding pages. In determining this adjustment, we assumed that the IRFs would regain 15 percent of potential losses and augment payment increases by 5 percent through transfers occurring at or beyond the mean length of stay associated with CMG or home health care at any point.

F. Development of the Federal Prospective Payment

Once the relative weights for each CMG and the budget neutral conversion factor are calculated, the Federal prospective payments can be determined. Under proposed § 412.624(c)(4), these CMG payments are calculated by multiplying the budget neutral conversion factor by each of the CMG relative weights. The equation is as follows:

Federal Prospective Payment = CMG Relative Weight * Budget Neutral Conversion Factor

Table 5E displays the CMGs and the corresponding Federal prospective payments.

TABLE 5E.—FEDERAL PROSPECTIVE PAYMENTS

CMG	Without comorbidities	With comorbidities
0101	$3,649.34	$3,983.67
0102	4,274.03	4,666.19
0103	5,183.65	5,658.95
0104	5,156.54	5,628.83
0105	5,795.09	6,325.80
0106	6,592.67	7,196.87
0107	7,608.31	8,305.29
0108	8,653.48	9,446.84
0109	9,631.77	10,514.89
0110	10,009.48	10,926.93
0111	11,822.70	12,906.42
0201	3,315.61	3,315.61
0202	5,014.98	5,014.98
0203	5,889.66	5,889.66
0204	7,011.94	7,011.94
0205	8,878.77	8,878.77
0206	13,360.63	13,360.63
0301	3,854.76	4,342.10
0302	5,055.94	5,695.09
0303	5,702.92	6,423.99
0304	7,593.25	8,552.88
0305	10,552.24	11,885.95
0401	4,298.12	5,156.54
0402	6,328.81	7,592.05
0403	10,517.30	12,616.67
0404	17,621.40	21,139.42
0501	2,686.10	3,330.07
0502	3,733.07	4,628.24
0503	4,910.76	6,088.46
0504	6,936.64	8,600.46
0505	10,732.36	13,306.41
0601	4,199.33	4,801.13
0602	5,473.41	6,258.33
0603	6,525.80	7,461.93
0604	8,057.10	9,211.90
0701	3,930.66	4,580.65
0702	5,022.21	5,852.92
0703	6,101.71	7,110.13
0704	7,104.71	8,278.78
0801	2,904.77	3,566.21
0802	3,604.76	4,425.23
0803	4,496.31	5,519.19
0804	5,322.20	6,533.03
0805	5,746.90	7,054.10
0806	7,087.24	8,699.26
0901	3,365.61	4,045.72
0902	4,602.94	5,533.04
0903	5,834.24	7,013.14
0904	7,315.55	8,793.23
1001	5,113.17	5,589.07
1002	6,733.63	7,360.73
1003	8,304.08	9,076.96
1101	3,671.63	4,511.37
1102	4,986.67	6,127.01
1103	6,562.55	8,063.73
1104	7,970.96	9,793.82
1201	3,593.32	4,124.63
1202	4,325.83	4,966.19
1203	5,530.63	6,349.30
1204	6,922.78	7,946.86
1301	3,570.42	4,131.86
1302	4,286.68	4,960.16
1303	6,295.08	7,284.82
1401	3,922.23	4,589.08
1402	5,425.21	6,347.49
1403	7,643.85	8,943.23
1501	4,663.18	5,016.18
1502	5,137.87	5,527.02
1503	7,153.50	7,695.06
1504	13,732.91	14,773.26
1601	3,705.36	4,405.35
1602	4,371.62	5,197.51
1603	5,858.34	6,964.95
1701	5,128.23	6,364.36
1702	8,239.02	10,225.14
1801	5,984.84	5,984.84
1802	12,387.15	12,387.15
1901	4,245.72	4,245.72
1902	6,555.92	6,555.92
1903	12,438.36	12,438.36
2001	3,018.02	3,375.85
2002	3,876.44	4,336.08
2003	4,498.72	5,031.85
2004	4,295.71	4,805.34
2005	5,149.92	5,760.15
2006	6,111.35	6,836.04
2007	6,022.80	6,736.64
2008	6,842.66	7,653.49
2009	7,518.55	8,409.50
2010	6,969.77	7,795.66
2011	8,974.56	10,038.39
2101	7,748.67	7,748.67
5001	1,149.38	1,149.38
5101	2,805.38	2,805.38
5102	6,492.06	6,492.06
5103	3,304.16	3,304.16
5104	9,052.26	9,052.26

G. Examples of Computing the Adjusted Facility Prospective Payments

The Federal prospective payments, described above, will be adjusted to account for geographic wage variation, disproportionate share and, if applicable, facilities located in rural areas.

To illustrate the methodology that we propose to use for adjusting the Federal prospective payments, we provide the following example. One beneficiary is in rehabilitation facility A and another beneficiary is in rehabilitation facility B. Rehabilitation facility A has a disproportionate share adjustment of 1.0648, a wage index of 0.987, and is located in a rural area. Rehabilitation facility B has a disproportionate share amount of 1.1337, a wage index of 1.234, and is located in an urban area. Both Medicare beneficiaries are classified to CMG 0111 (without

comorbidity). This CMG represents a stroke with motor scores in the 78–61 range and the patient is 83 years old or younger. To calculate the facility's total adjusted Federal prospective payment, we compute the wage adjusted Federal prospective payment and multiply the result by: the appropriate disproportionate share adjustment, and the rural adjustment (if applicable). Table 6E illustrates the components of the adjusted payment calculation.

TABLE 6E.—EXAMPLES OF COMPUTING A FACILITY'S FEDERAL PROSPECTIVE PAYMENT

		Facility A
Federal Prospective Payment (From Table 5E)	$11,822.70	$11,822.70
Labor Share (From Table 2E)	× .71301	× .71301
Labor Portion of Federal Payment	= $8,429.70	= $8,429.70
Wage Index (From Tables 3E or 4E)	× 0.987	× 1.234
Wage Adjusted Amount	$8,320.12	$10,402.25
Non-Labor Amount	+ $3,393.00	+ $3,393.00
Wage Adjusted Federal Payment	= $11,713.11	= $13,795.25
Rural Adjustment	× 1.1589	× 1.0000
Subtotal	= $13,574.33	= $13,795.25
DSH Adjustment	× 1.0648	× 1.1337
Total Adjusted Federal Prospective Payment	$14,453.94	$15,639.68

Thus, the adjusted payment for facility A will be $14,453.64 and the adjusted payment for facility B will be $15,639.68.

H. Computing Total Payments

As described in proposed § 412.626, for cost reporting periods beginning on or after April 1, 2001 and before October 1, 2001, payments will be based on 66⅔ percent of the facility specific payment and 33⅓ percent of the IRF adjusted facility Federal prospective payment. The facility specific payment is the amount the facility would have been paid if the prospective payment system had not been implemented. Medicare fiscal intermediaries will continue to compute the facility specific payment amount according to § 412.22(b) of the regulations and sections 1886(d) and (g) of the Act.

I. Method of Payment

A beneficiary will be classified into a CMG based on data obtained during the initial MDS–PAC assessment. The CMG will determine the Federal prospective payment the IRF will receive for the Medicare-covered Part-A services the IRF furnished during the Medicare beneficiary's episode of care. However, we are proposing, under § 412.632(a), that the payment be based on the submission of a discharge bill. This will allow us to account for the occurrence of an event during the stay which would result in a reclassification to one of the five special CMGs (for cases that expire or have a very short length of stay) or an adjustment to the payment to reflect an early transfer and determine if the case qualifies for an outlier payment. Accordingly, the CMG and other information to determine if an adjustment to the payment is necessary will be recorded by the IRF on the beneficiary's discharge bill and submitted to its Medicare fiscal intermediary for processing. The payment made represents payment in full, under proposed § 412.622(b), for inpatient operating and capital costs, but not for the costs of an approved medical education program, bad debts, or other costs not paid for under the proposed IRF prospective payment system.

Under the current payment system, (1) An IRF may be paid using the periodic interim payment (PIP) method described in § 413.64(h) of the regulations, (2) rehabilitation units are paid under the PIP method if the hospital of which they are a part is paid under § 412.116(b), and (3) IRFs may be eligible to receive accelerated payments as described in § 413.64(g) or for rehabilitation units under § 412.116(f). We presently see no reason to discontinue administratively our existing policy of allowing the PIP and accelerated payment methods under the prospective payment system for qualified IRFs, though we may choose to evaluate its continuing need in the future. Therefore, we are proposing to permit the continued availability of PIP and accelerated payments for services of IRFs paid under the prospective payment system at proposed paragraphs (b) and (e) of § 412.632 of the regulations.

For those services paid under the PIP method, the amount is based on estimated prospective payments for the year rather than on estimated cost reimbursement. An IRF receiving prospective payments, whether or not it received a PIP prior to receiving prospective payments, may receive a PIP if it meets the requirements in § 412.632 and receives approval by its intermediary. Likewise, if an intermediary determines that an IRF which received a PIP prior to receiving prospective payments is no longer entitled to receive a PIP, it will remove the IRF from the PIP method. As provided in § 412.632, intermediary approval of a PIP is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

Excluded from the PIP amount are outlier payments that are paid in final upon the submission of a discharge bill. In addition, Part A costs that are not paid for under the IRF prospective payment system, including Medicare bad debts and costs of an approved educational program, will be subject to the interim payment provisions of the regulations at § 413.64.

Under the prospective payment system, if an IRF is not paid under the PIP method it may qualify to receive an accelerated payment. Under § 412.632, the IRF must be experiencing financial difficulties due to a delay by the intermediary in making payment to the IRF or there is a temporary delay in the IRF's preparation and submittal of bills to the intermediary beyond its normal billing cycle because of an exceptional situation. A request for an accelerated payment must be made by the IRF and approved by the intermediary and

HCFA. The amount of an accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services. Recoupment of an accelerated payment is made as bills are processed or by direct payment by the IRF.

J. Update to the Adjusted Facility Federal Prospective Payment

Under section 1886(j)(3)(C) of the Act and under proposed § 412.624(c)(3)(ii) of the regulations, future updates to the adjusted facility Federal prospective payments (budget neutral conversion factor) will include the use of an increase factor based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under the proposed IRF prospective payment system. This increase factor may be the market basket percentage increase described in section 1886(b)(3)(B)(iii) of the Act. A description of IRF market basket that we propose to use in developing an increase factor under section 1886(j)(3)(C) is found in Appendix D of this proposed rule.

VI. Provisions of the Proposed Rule

We are proposing to make a number of revisions to the regulations in order to implement the prospective payment system for inpatient rehabilitation facilities. We are proposing to make conforming changes in 42 CFR parts 412 and 413. We are proposing to establish a new subpart P in part 412, ''Prospective Payment for Inpatient Rehabilitation Facilities''. This subpart would implement section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation facilities. This subpart would set forth the framework for the inpatient rehabilitation facility prospective payment system, including the methodology used for the development of the payment rates and related rules. These revisions and others are discussed in detail below.

Section 412.1 Scope of Part

We are proposing to revise § 412.1 by redesignating paragraph (a) as paragraph (a)(1) and adding a paragraph (a)(2) that specifies that this part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services provided to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit for cost reporting periods beginning on or after April 1, 2001. As a result of our proposed changes to § 412.1, we would make a number of conforming changes to various sections of the regulations text. These changes include adding references to the inpatient hospital prospective payment systems as described in § 412.1(a)(1).

Currently, § 412.1(b) ''Summary of content'' describes the content of each subpart in part 412. To make this paragraph more user friendly, we would restructure the paragraph by dividing it into 12 subparagraphs. In addition, we would add references to § 412.1(a)(1)(where appropriate) and add a new subparagraph (b)(12) that summarizes the content of the new subpart P.

Section 412.20 Hospital Services to the Prospective Payment Systems

We propose to revise § 412.20 by revising paragraph (a) to add a reference to inpatient hospital prospective payment system, redesignating paragraph (b) as paragraph (c), and adding a new paragraph (b). Section 412.20(b) would specify that effective for all cost reporting periods beginning on or after April 1, 2001, the services furnished by an inpatient rehabilitation hospital or rehabilitation unit specified in § 412.604 are paid for under the prospective payment system described in subpart P. We would also add a reference to § 412.1(a)(1) to the introductory text of § 412.20(c).

Section 412.22 Excluded Hospitals and Hospital Units: General Rules

We propose to revise §§ 412.22(a), (b), (e), and (h)(2) to add references to § 412.1(a)(1) or § 412.20 (b).

Section 412.23 Retroactive Adjustments for Incorrectly Excluded Hospital Units

We propose to revise the introductory text of §§ 412.23 and 412.23(b)(2) to add references to § 412.1(a)(1) and (a)(2). We propose to revise the introductory text of paragraph (b) to add references to § 412.1(a)(1) and (a)(2). We proposed to revise paragraphs (b)(8) and (b)(9) to specify that in order to be classified as a rehabilitation hospital a patient assessment instrument must be completed in accordance with § 412.606 for each Medicare patient admitted or discharged on or after April 1, 2001.

Section 412.25 Excluded Hospital Units: Common Requirements

We propose to revise §§ 412.25(a) and (e)(2) to add references to § 412.1(a)(1).

Section 412.29 Excluded Rehabilitation Units: Additional Requirements

We propose to revise the introductory text of § 412.29 to add a reference to § 412.1(a)(1) and (a)(2).

Section 412.116 Method of Payments

We propose to restructure and revise paragraph (a) by creating paragraphs (a)(1) and (a)(2). New paragraph (a)(2) would be revised to specify that payments for inpatient hospital services furnished by an excluded psychiatric or rehabilitation unit (not paid under the provisions of subpart P of this part) are made as described in § 413.64(a), (c), (d) and (e) of this chapter. We also propose to add a new paragraph (a)(3) that specifies how payments for inpatient hospital services are made to a qualified IRF.

Section 412.130 Retroactive Adjustments for Incorrectly Excluded Hospital Units

We would revise paragraphs (a)(1) and (a)(2) to add references to §§ 412.1(a)(1) and (a)(2). In addition, § 412.130 (a)(1) and (a)(2) would be revised to specify that for cost reporting periods on or after October 1, 1991, rehabilitation hospitals and units that were excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the inpatient rehabilitation prospective payment system, as a new rehabilitation hospital or unit will have its payments adjusted if the inpatient population actually treated in the hospital during the cost reporting period did not meet the requirements of § 412.23(b)(2). In § 412.130(b), we would add the provisions that specify that the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section for cost reporting periods beginning on or after April 1, 2001 as follows:

- The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems described in § 412.1(a)(1) for services furnished during that period.
- The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems described in § 412.1(a)(1).

Subpart P Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

We propose to reserve subparts N and O, and add a new subpart P.

Section 412.600 Basis and Scope of the Subpart

We are proposing to add a new § 412.600. Section 412.600(a) provides for the implementation of a prospective payment system for inpatient rehabilitation facilities. In § 412.600(b), we would specify that this subpart sets forth the framework for the prospective payment system, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules for inpatient rehabilitation facilities for cost reporting periods beginning on or after April 1, 2001.

Section 412.602 Definitions

In § 412.602, we are proposing the following definitions for purposes of this new subpart:

- Assessment reference date;
- Authorized clinician;
- Discharge;
- Encode;
- Functional-related groups;
- Interrupted stay;
- MDS–PAC;
- Outlier payment;
- Rural area
- Transfer; and
- Urban area.

Section 412.604 Conditions for Payment Under the Prospective Payment System for Inpatient Rehabilitation Facilities

In proposed § 412.604(a), we would specify that IRFs must meet the following general requirements to receive payment under the IRF prospective payment system:

- The IRF must meet the conditions of this section;
- If the IRF fails to comply with the provisions of the section then we can—
- Withhold (in full or in part) or reduce payment to the IRF; or
- Classify the IRF as an inpatient hospital subject to the inpatient hospital prospective payment system.

In proposed paragraph (b), we would specify that an IRF must meet the rehabilitation hospital or rehabilitation unit classification criteria set forth in §§ 412.22, 412.23(b) and 412.30 for exclusion from the inpatient hospital prospective payment system. In addition, we propose to specify that qualifying IRFs are subject to the payment provisions for the IRF prospective payment system.

Proposed paragraph (c) would specify that the IRF must complete a patient assessment instrument for each Medicare patient admitted or discharged on or after April 1, 2001.

Proposed paragraph (d) would specify the prohibited and permitted charges that can be imposed on Medicare beneficiaries. In proposed paragraph (d)(1), we would specify that an IRF may not charge a beneficiary for any services for which payment is made by Medicare, even if the IRF's costs are greater than the amount the facility is paid under the IRF prospective payment system. In addition, proposed paragraph (d)(2) would specify that an IRF receiving payment for a covered stay may charge the Medicare beneficiary or other person for only the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87.

Proposed paragraph (e) would specify the following provisions for furnishing IRF services directly or under arrangements:

- Applicable payments made under the IRF prospective payment system are in full for all inpatient hospital services (as defined in § 409.10) other than physicians' services to individual patients (as specified in § 415.102(a)) which are reimbursable on a reasonable cost basis.
- Payment is not made to a provider or supplier other than the IRF, except for physicians' services reimbursable under § 405.550(b) and the services of an anesthetist employed by a physician reimbursable under § 415.102(a).
- The IRF must furnish all necessary covered services to the Medicare beneficiary directly or under arrangements (as defined in § 409.3).

Lastly, proposed paragraph (f) would specify that IRFs must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24.

Section 412.606 Patient Assessments

In proposed § 412.606, we set forth the requirements regarding patient assessment. Proposed § 412.606(a) would specify that at the time each Medicare patient is admitted the facility must have physician orders for the patient's care during his or her hospitalization. Proposed § 412.606(b) would specify that MDS–PAC is the instrument used to assess Medicare inpatients who are admitted on or after April 1, 2001, or were admitted before April 1, 2001, and are still inpatients as of April 1, 2001. In proposed § 412.606(c), we would specify that an inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS–PAC. This assessment must be in accordance with the assessment schedule. A clinician must record appropriate and applicable data accurately and completely for each MDS–PAC item. The assessment process must include direct patient observation and communication with the patient; and when appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, the patient's clinical record and other sources. The authorized clinician must sign the MDS–PAC attesting to its completion and accuracy.

Section 412.608 Patients' Rights Regarding MDS–PAC Data Collection

Proposed § 412.608 specifies patient rights regarding MDS–PAC data collection. In proposed paragraph (a) we would specify the rights that a Medicare inpatient must be informed of by the IRF authorized clinician before an assessment can be performed. Proposed paragraph (b) would require the authorized clinician to document in the Medicare inpatient's clinical record that the patient was informed of the rights listed in paragraph (a). Proposed paragraph (c) specifies that the patient rights included in this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

Section 412.610 Assessment Schedule

In proposed § 412.610, we would specify the following:

- The start of the assessment schedule day count.
- The determination of the assessment reference date.
- The date when an MDS–PAC assessment reference is late.
- MDS–PAC completion and encoding dates.
- The accuracy of the MDS–PAC data.
- The length of time that an IRF has to retain MDS–PAC patient data sets.

Section 412.612 Coordination of MDS–PAC Data Collection

We proposed to add a new § 412.612. Paragraph (a) of this section would specify the responsibilities of the IRF's authorized clinician. Section 412.612(b) states that the IRF's authorized clinician must certify the accuracy and completion date of the MDS–PAC assessment by signing and dating the appropriate lines of section AB of the MDS–PAC. Proposed paragraph (c) specifies the signature requirements for any clinician who contributes data for an MDS–PAC item. Proposed paragraph (d) specifies the penalty for falsification of a patient assessment.

Section 412.614 Transmission of MDS–PAC Data

Proposed § 412.614 specifies the requirements for transmittal of MDS–PAC data that include the following:

- The format for submitting data.
- How the data is to be submitted.
- The timeframe for submitting data.
- The penalties for late transmission of data.

Section 412.616 Release of Information Collected Using the MDS–PAC

In proposed § 412.616, we specify that the IRF and its agents must ensure the confidentiality of the information collected using the MDS–PAC in the same manner as all other information in the medical record, in accordance with the hospital conditions of participation at § 482.24(b)(3). An IRF may release patient-identifiable information to an agent of the IRF only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purpose specified in the contract and only to the extent that the IRF itself is permitted to so under § 412.616(a).

Section 412.618 Interrupted Stay

In proposed § 412.618 (a), we specify that for purposes of the MDS–PAC assessment process, if a Medicare inpatient has an interrupted stay then the following applies:

- The initial case-mix group classification from the ''initial'' (Day 4) MDS–PAC assessment remains in effect.
- The required scheduled MDS–PAC Day 11, Day 30, Day 60, and discharge assessments must be performed.
- The authorized clinician must record the interrupted stay data on the interrupted stay tracking form of the MDS–PAC.
- The recorded and encoded interrupted stay data must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date that the Medicare patient returns to IRF. In proposed paragraph (d), we specify the revised assessment schedule. Proposed paragraph (d)(1) specifies that if the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission for the Day 4 and Day 11 MDS–PAC assessments are advanced by the same number of calendar days as the length of the Medicare patient's interrupted stay. Proposed paragraphs (d)(2), (d)(3) and (d)(4), specify the provisions under which the Day 11, Day 30, and Day 60 are advanced in the same manner.

Section 412.620 Patient Classification System

Proposed § 412.620 specifies the classification methodology, weighting factors, and case-mix adjustments as they relate to the patient classification system.

Section 412.622 Basis of Payment

Proposed § 412.622(a), we would specify that under the prospective payment system, IRFs received a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries. This paragraph also specifies the basis for the amount of payment under the prospective system.

Proposed § 412.622(b) specifies that payments made under the prospective payment system represent payment in full for inpatient operating and capital costs associated with services furnished in an IRF, but not for the costs of an approved medical education program. Paragraph (b) also specifies the additional payments that an IRFs receive.

Section 412.624 Methodology for Calculating the Prospective Payment Rates

This proposed section specifies the methodology for calculating the prospective payment rates for IRFs. The items specified in this section are as follows:

- Proposed paragraph (a) specifies the data used to calculate the prospective payment rates;
- Proposed paragraph (b) specifies the methodology for calculating the Federal per discharge payment rates that includes—
- Determination of the per discharge payment rate; and
- Adjustments to the data.
- Proposed paragraph (c) specifies how the Federal prospective payment rates for IRFs will be determined. This includes the general rules, the update per discharge, the computation of the budget neutral conversion factor and the determination of the Federal prospective payment rate for each case-mix group.
- Proposed paragraph (d) specifies the adjustments to the budget neutral conversion factor. The adjustments include the following: (1) outlier payments; (2) budget neutrality; and (3) coding and classification changes.
- Proposed paragraph (e) specifies the calculation of the adjusted Federal prospective payment is computed for each discharge on the basis of the Federal prospective payment rate determined in paragraph (c) of this section and adjusted to account for area wage levels, payments for outliers, transfers, and other appropriate factors.

Section 412.626 Transition Period

Proposed § 412.626(a) specifies the duration of the transition period to IRF prospective payment system. It also specifies that IRFs will receive a payment that is comprised of a blend of the adjusted facility Federal prospective payment and the facility-specific payment. Proposed paragraph (b) specifies how the facility-specific payment is calculated.

Section 412.628 Publication of the Federal Prospective Payment Rates

Proposed § 412.628 specifies that we will publish information pertaining to the IRF prospective payment system effective for each fiscal year in the **Federal Register**. In addition, it specifies that the information regarding the IRF prospective payment system will be published on or before August 1 prior to the beginning of each fiscal year.

Section 412.630 Limitation on Review

Proposed § 412.630 specifies that administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

Section 412.632 Method of Payment Under the Inpatient Rehabilitation Facility Prospective Payment System

Proposed § 412.632 specifies the method of payment under the inpatient rehabilitation facility prospective payment system. This section specifies the following:

- General rule for receiving payment, including exceptions;
- The requirements for periodic interim payments that include—
- Criteria for receiving periodic interim payments;
- Frequency of payments; and
- Termination of periodic interim payments;
- Interim payment for Medicare bad debts and for Part A costs not paid under the prospective payment system.
- Outlier payments.
- The requirements for accelerated payments that include—
- General rule regarding request for accelerated payments;
- Approval of request for accelerated payments;
- Amount of the accelerated payment; and

• Recovery of the accelerated payment.

Section 413.1 Introduction

We propose to revised § 413.1(d)(ii) to remove the reference to rehabilitation hospitals and units. We also propose to add a new § 413.1(d)(iv) that specifies that for cost reporting periods beginning on or before April 1, 2001, payment to rehabilitation hospitals and units that are excluded under subpart B of part 412 of this subchapter from the prospective payment system is on a reasonable cost basis in accordance with the provisions of § 413.40. In addition, we propose to add a new § 413.1(d)(v) that specifies that for cost reporting periods on or after April 1, 2001, payment to rehabilitation hospitals and units (as described in § 412.604) is based on the prospectively determined rates under the provisions of subpart P of part 412.

Section 413.40 Ceiling on the Rate of Increase in Hospital Costs

Section 413.40(a)(2)(i) specifies the types of facilities to which the ceiling on the rate of increase in hospital inpatient costs is not applicable. We propose to add a new paragraph § 413.40(a)(2)(i)(C) to specify that for cost reporting periods beginning on or after October 1, 2002, § 413.40 is not applicable to rehabilitation hospitals and rehabilitation units that meet the conditions for payment under § 412.604 and are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) and subpart P of part 412.

We propose to revise § 413.40(a)(2)(ii) and to add (a)(2)(iii) to specify the cost reporting periods under which rehabilitation hospitals and units that are excluded from the prospective payment system specified in § 412.1(a)(1) meet the terms of this section

Section 413.64 Payment to Providers: Specific Rules

We propose to revise § 413.64 to include hospitals paid under the IRF prospective payment system and add a reference to § 412.1(a)(1).

VII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and we will respond to the comments in the preamble to the final rule.

VIII. Regulatory Impact Analysis

Section 804(2) of title 5, United States Code (as added by section 251 of Public Law 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

• An annual effect on the economy of $100 million or more;

• A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or

• Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States-based enterprises to compete with foreign based enterprises in domestic and export markets.

We have examined the impacts of this proposed rule as required by Executive Order (EO) 12866, the Unfunded Mandates Reform Act of 1995 (Public Law 104–4), the Regulatory Flexibility Act (RFA) (Public Law 96–354), and EO 13132 (Federalism). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). This proposed regulation would be a major rule because the aggregate amount of savings is estimated to be 1.54 billion dollars over 7 years.

The RFA requires agencies to analyze options for regulatory relief of small entities. For purposes of the RFA, businesses include small businesses, non-profit organizations and governmental agencies. Most hospitals and most other providers and suppliers are small entities, either by nonprofit status or by having revenues of $5 million or less annually. Intermediaries and carriers are not considered to be small entities. Individuals and States are not included in the definition of a small entity.

Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in an expenditure in any one year by State, local, or Tribal governments, in the aggregate, or by the private sector, of at least $100 million. This rule will not have an effect on the governments mentioned nor will it affect private sector costs, rather, the proposed rule will affect Medicare payments.

In addition, we examined this rule in accordance with Executive Order 13132 and determined that this proposed rule would not have any negative impact on the rights, roles, or responsibilities of State, local, or Tribal governments.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any proposed rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 604 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside of a Metropolitan Statistical Area and has fewer than 50 beds.

For these reasons, we are preparing analyses under the RFA and section 1102(b) of the Act because we determine, and we certify, that this proposed rule would have a significant economic impact on a substantial number of small entities or a significant impact on the operations of a substantial number of small rural hospitals. As discussed earlier in this preamble, we propose to adjust payments for facilities located in rural areas. Therefore, the impacts shown below reflect the adjustments that are designed to minimize or eliminate the negative impact that the prospective payment system would otherwise have on rural facilities.

A. Background

This proposed rule sets forth the prospective payments to be used to determine payments under the Medicare program for inpatient rehabilitation facilities.

While section 1886(j) of the Act specifies the basic methodology of constructing a case-mix adjusted prospective payment system, the statute does allow us some discretion in designing the key elements of the system, and we had some opportunity to consider alternatives for these elements. These include the patient assessment instrument, the patient classification methodology based on functional-related groups, and adjustments to the prospective payments. These elements, and alternatives that we considered, were discussed in detail earlier in the preamble of this proposed rule.

B. Anticipated Effects of This Proposed Rule

We discuss the impact of this proposed rule in terms of its fiscal impact on the budget and in terms of its

impact on providers. The estimated fiscal impact is discussed first.

1. Budgetary Impact

Under section 1886(j)(3)(B) of the Act, payment rates set forth in this proposed rule must be set at levels such that total payments under this prospective payment system are projected to equal 98 percent of the amount that would have been paid for operating and capital costs if this prospective payment system had not been implemented. The provision to implement the IRF prospective payment system is projected to save the Medicare program $1.54 billion over 7 years, as follows:

$60 million for FY 2001
$200 million for FY 2002
$220 million for FY 2003
$240 million for FY 2004
$250 million for FY 2005
$270 million for FY 2006
$300 million for FY 2007

2. Impacts on Providers

In order to understand the impact of the new prospective payment system on different categories of facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the proposed prospective payment system (proposed prospective payments). To estimate the impacts among the various classes of providers it is imperative that current payments and proposed prospective payments contain similar inputs. More specifically, we simulate proposed prospective payments only for those providers that we are able to calculate current payment. Further, we calculate current payment only for those providers that we are able to simulate proposed prospective payments.

As previously stated in section V. of this preamble, we have both case-mix and cost data for 624 rehabilitation facilities. Data from these facilities were used to analyze the appropriateness of various adjustments to the Federal unadjusted payment rates. However, for the impact analyses shown in the following tables, we simulate payments for 505 facilities. These impacts reflect the estimated losses/gains among the various classifications of providers for FY 2001. The methodology used to update the data to the midpoint of FY 2001, necessitated the use of historical cost report data to determine the relationship of the facilities' costs and target amount. Thus, the number of providers reflects only those providers for which we had cost report data available from FYs 1995, 1996, and 1997 (see discussion in section V.E.1. of this proposed rule).

3. Calculation of Current Payments

To calculate current payments, cost report data is trended forward from the midpoint of the cost reporting period to the midpoint of FY 2001 using the methodology set forth in section V. of this preamble. To estimate current payments, we calculate operating payments for each rehabilitation facility in accordance with section 1886(b). Further, we compute capital payments by reducing reasonable costs by 15 percent, consistent with section 1886(g)(4) of the Act, as added by section 4412 of the BBA. To determine each facility's average per discharge payment amount under the current payment system, operating and capital payments are added together, and then the total payment is divided by the number of Medicare discharges from the cost reports. Total payments for each facility are then computed by multiplying the number of discharges from the Medicare bills (with corresponding UDSmr/COS data) by the average per discharge payment amount.

4. Calculation of Proposed Prospective Payments

To estimate payments under the proposed prospective payment system, we multiply each facility's case-mix index by the facility's number of Medicare discharges, the budget neutral conversion factor, the applicable wage index, a disproportionate share adjustment, and a rural adjustment, (if applicable). The specific adjustments follow:

- The wage adjustment is calculated as (.2897 + (.7103 × Wage Index)),
- The disproportionate share adjustment is calculated as:

((.0001 + Disproportionate Share) raised to the power of .0905)/(.0001 raised to the power of .0905)),

- The rural adjustment, if applicable, is calculated by multiplying payments by 1.1589.

After the proposed Federal rate payments are calculated for each facility, the appropriate percentages of the current payments and the proposed Federal rate payments are blended together to determine the appropriate amount for the first three years of implementation of the IRF prospective payment system. Specifically, for cost reporting periods beginning on or after implementation of the prospective payment system through FY 2001 we combine 66⅔ percent of the current payment amount with 33⅓ percent of the proposed Federal rate payment amount. For cost reporting periods beginning in FY 2002, we combine 33⅓ percent of the current payment amount with 66⅔ percent of the proposed Federal rate payment amount. For cost reporting periods beginning in FY 2003, we show the impacts of the fully phased-in IRF prospective payment amount. All payment simulations reflect data trended to the midpoint FY 2001. These data were not trended out to the midpoint of FYs 2002 or 2003.

Tables 1G, 2G, and 3G illustrate the aggregate impact of the proposed payment system among various classifications of facilities. The first column, Facility Classifications, identifies the type of facility. The second column identifies the number of cases. The third column lists the number of facilities of each classification type, and the fourth column is the ratio of proposed prospective payments to current payments. The impacts reflect the adjustments that we propose, including the specific geographic wage adjustment, the adjustment for rural facilities (if applicable), and a disproportionate share adjustment for all facilities.

TABLE 1G.—IMPACTS REFLECTING ⅓ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅔ OF CURRENT PAYMENTS

Facility classifications	Number of cases	Number of Facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.98
Other Urban	88232	238	0.98

TABLE 1G.—IMPACTS REFLECTING ⅓ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅔ OF CURRENT PAYMENTS—Continued

Facility classifications	Number of cases	Number of Facilities	Proposed payment to current payment ratio
Rural	9814	49	1.00
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.98
South Atlantic	34845	79	0.99
East North Central	33018	120	0.98
East South Central	12344	26	1.00
West North Central	9175	44	0.98
West South Central	22995	73	0.95
Mountain	5659	25	0.96
Pacific	9097	55	0.99
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.98
Urban—South Atlantic	31314	72	1.00
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	0.99
Urban—West North Central	7979	36	0.98
Urban—West South Central	21929	64	0.95
Urban—Mountain	5349	22	0.96
Urban—Pacific	8610	51	0.99
Rural by Region			
Rural—New England	118	1	1.01
Rural—Middle Atlantic	586	3	1.01
Rural—South Atlantic	3531	7	0.99
Rural—East North Central	2025	12	1.03
Rural—East South Central	495	2	1.09
Rural—West North Central	1196	8	0.98
Rural—West South Central	1066	9	0.96
Rural—Mountain	310	3	1.02
Rural—Pacific	487	4	0.97
Type and Size of Facility			
Unit of acute hospital	101518	398	0.99
Average Daily Census < 10	12962	102	0.98
Average Daily Census 10–24	51783	211	0.99
Average Daily Census > 24	36773	85	0.99
Freestanding hospital	65872	107	0.96
Average Daily Census less than 25	3527	18	0.96
Average Daily Census 25–50	19248	40	0.97
Average Daily Census greater than 50	43097	49	0.96
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.98
Disproportionate share 10%–19%	56138	190	0.99
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	0.99
Missing	14379	28	0.97
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.98
Resident to ADC 10%–19%	7309	20	0.97
Resident to ADC greater than 19%	1267	11	0.97
Alaska/Hawaii	1099	2	0.99

TABLE 2G.—IMPACTS REFLECTING ⅔ OF PROPOSED PROSPECTIVE PAYMENTS PLUS ⅓ OF CURRENT PAYMENTS

Facility classifications	Number of cases	Number of facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.99
Other Urban	88232	238	0.97
Rural	9814	49	1.01
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.97
South Atlantic	34845	79	1.01
East North Central	33018	120	0.98
East South Central	12344	26	1.01
West North Central	9175	44	0.98
West South Central	22995	73	0.93
Mountain	5659	25	0.94
Pacific	9097	55	0.99
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.97
Urban—South Atlantic	31314	72	1.01
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	1.01
Urban—West North Central	7979	36	0.99
Urban—West South Central	21929	64	0.93
Urban—Mountain	5349	22	0.93
Urban—Pacific	8610	51	0.99
Rural by Region			
Rural—New England	118	1	1.04
Rural—Middle Atlantic	586	3	1.03
Rural—South Atlantic	3531	7	1.00
Rural—East North Central	2025	12	1.08
Rural—East South Central	495	2	1.20
Rural—West North Central	1196	8	0.97
Rural—West South Central	1066	9	0.95
Rural—Mountain	310	3	1.06
Rural—Pacific	487	4	0.96
Type and Size of Facility			
Unit of acute hospital	101518	398	1.00
Average Daily Census < 10	12962	102	0.99
Average Daily Census 10–24	51783	211	1.00
Average Daily Census > 24	36773	85	1.00
Freestanding hospital	65872	107	0.95
Average Daily Census less than 25	3527	18	0.93
Average Daily Census 25–50	19248	40	0.95
Average Daily Census greater than 50	43097	49	0.95
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.97
Disproportionate share 10%–19%	56138	190	0.99
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	1.01
Missing	14379	28	0.96
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.99
Resident to ADC 10%–19%	7309	20	0.96
Resident to ADC greater than 19%	1267	11	0.95
Alaska/Hawaii	1099	2	1.00

TABLE 3G.—IMPACTS REFLECTING THE FULLY PHASED-IN PROSPECTIVE PAYMENTS

Facility classifications	Number of cases	Number of facilities	Proposed payment to current payment ratio
All Facilities	167390	505	0.98
Geographic Location			
Large Urban	69344	218	0.99
Other Urban	88232	238	0.97
Rural	9814	49	1.03
Region			
New England	15320	37	0.98
Middle Atlantic	24937	46	0.97
South Atlantic	34845	79	1.02
East North Central	33018	120	0.99
East South Central	12344	26	1.03
West North Central	9175	44	0.99
West South Central	22995	73	0.90
Mountain	5659	25	0.92
Pacific	9097	55	1.00
Urban by Region			
Urban—New England	15202	36	0.98
Urban—Middle Atlantic	24351	43	0.97
Urban—South Atlantic	31314	72	1.03
Urban—East North Central	30993	108	0.98
Urban—East South Central	11849	24	1.02
Urban—West North Central	7979	36	0.99
Urban—West South Central	21929	64	0.90
Urban—Mountain	5349	22	0.91
Urban—Pacific	8610	51	1.00
Rural by Region			
Rural—New England	118	1	1.07
Rural—Middle Atlantic	586	3	1.06
Rural—South Atlantic	3531	7	1.01
Rural—East North Central	2025	12	1.13
Rural—East South Central	495	2	1.31
Rural—West North Central	1196	8	0.97
Rural—West South Central	1066	9	0.93
Rural—Mountain	310	3	1.10
Rural—Pacific	487	4	0.96
Type and Size of Facility			
Unit of acute hospital	101518	398	1.01
Average Daily Census < 10	12962	102	0.99
Average Daily Census 10–24	51783	211	1.02
Average Daily Census > 24	36773	85	1.02
Freestanding hospital	65872	107	0.93
Average Daily Census less than 25	3527	18	0.91
Average Daily Census 25–50	19248	40	0.94
Average Daily Census greater than 50	43097	49	0.93
Disproportionate Share			
Disproportionate share less than 10%	76374	197	0.97
Disproportionate share 10%–19%	56138	190	1.00
Disproportionate share 20%–29%	13308	58	0.98
Disproportionate share greater than 29%	7191	32	1.03
Missing	14379	28	0.94
Teaching Status			
Non-Teaching	132437	407	0.98
Resident to ADC less than 10%	26377	67	0.99
Resident to ADC 10%–19%	7309	20	0.95
Resident to ADC greater than 19%	1267	11	0.94
Alaska/Hawaii	1099	2	1.00

5. Costs Associated With The MDS-PAC

We propose that all IRFs furnishing Medicare-covered Part A services assess their Medicare patients using the standardized data set known as the MDS–PAC. Costs associated with MDS–PAC data collection and data reporting are related to both personnel and equipment. These two classes of costs include the costs associated with using the MDS–PAC to assess patients (MDS–PAC data collection costs), the IRF's costs to start the MDS–PAC process, and the IRF's ongoing costs after the MDS–PAC process has been initiated. It should be noted that many of the components of the costs associated with initiation of the MDS–PAC process and the IRF's ongoing costs are the same.

a. MDS–PAC Data Collection Costs

In calculating the cost to perform an MDS–PAC assessment we made the following assumptions: (1) That physicians, registered nurses, occupational therapists, or physical therapists are the only clinicians with the training to complete all, or the vast majority, of the MDS–PAC items. Other clinicians may contribute data to complete some MDS–PAC items. (2) That a physician would not record the data for all or most of the MDS–PAC items. We believe that the majority of the items would be completed by registered nurses, occupational therapists, or physical therapists.

We then applied the above assumptions to the following data:

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of registered nurses in 1998 were $40,690. That is equivalent to a median hourly wage of $19.56. ($40,690/52 weeks = $782.50/week. $782.50/40 hours = $19.5625).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of occupational therapists in 1998 were $48,230. That is equivalent to a median hourly wage of $23.19. ($48,230/52 weeks = $927.50. $927.50/40 hours = $23.1875).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of physical therapists in 1998 were $56,600. That is equivalent to a median hourly wage of $27.21. ($56,600/52 weeks = $1088.46/week. $1088.46/40 hours = $27.2115).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of dietitians and nutritionists in 1998 were $35,020. That is equivalent to a median hourly wage of $16.84. ($35,020/52 weeks = $673.46/week. $673.46/40 hours = $16.8365).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of social workers in 1998 were $30,590. That is equivalent to a median hourly wage of $14.71. ($30,590/52 weeks = $588.27/week. $588.27/40 hours = $14.7067).

• According to the Occupational Outlook Handbook of the Bureau of Labor Statistics, U.S. Department of Labor, the median earnings of speech-language pathologists and audiologists in 1998 were $43,080. That is equivalent to a median hourly wage of $20.71. ($43,080/52 weeks = $828.46/week. $828.46/40 hours = $20.7115).

• IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 85 minutes to complete an initial intake assessment.

• IRF staff familiar with the MDS–PAC that was the product of our pilot and field testing required a median of 48 minutes to complete an update assessment.

• According to one external source IRF staff familiar with the UDSmr FIM required a median of 20 minutes to complete the initial FIM instrument.

• According to another external source IRF staff familiar with the FIM required a range of 30 to 45 minutes to complete the FIM instrument. It was not specified if this was the UDSmr or COS instrument. Also, although it was not specified, we believe that this range of time was the time to complete an initial FIM assessment.

• It should be noted that the information from both external sources concerning the length of time it takes to complete the FIM instrument has not been verified.

• Our data indicates that in 1997 there were 359,032 IRF admissions and 1,123 IRFs. Therefore, there were an average of 319.70 admissions per IRF.

Based on the above data and assumptions, and depending on the type of clinician that completes all, or the vast majority, of the MDS–PAC items, the range of the incremental average cost difference per year per IRF to complete the initial MDS–PAC when compared to the initial FIM is illustrated in Table 4G below. In addition, considering the hourly wage rates specified above it would make no difference in cost if a dietitian or social worker completed all or most of the MDS–PAC items, and only a slight difference at the low end of the range if a speech-language pathologist completed all or most of the MDS–PAC items.

TABLE 4G.—RANGE OF INCREMENTAL COST—COMPARISON OF THE INITIAL MDS–PAC TO THE INITIAL FIM

Range of hourly wages per clinician	Minimum incremental time of 40 minutes—range of Incremental Cost per IRF per year	Maximum incremental time of 65 minutes—range of incremental cost per IRF per year
$19.56 (R.N.)	$4,169.02	$6,774.61
23.19 (O.T.)	4,942.72	8,031.86
27.21 (P.T.)	5,799.54	9,424.18

We believe that the FIM data are inconclusive, and we have several concerns and observations regarding the data. The data from both external sources were collected from a survey of a sample of IRFs. We do not know the size of one of the samples, and if either sample is representative of all IRFs. We do not know if the data are estimates of time or controlled measurements of time. Nor do we know the details of the survey method that was used to collect the data. The data may be biased at the source where the data was collected, that is, the sources of the data may be reflecting institutionalized biases when reporting their data. In addition, the data was reported by organizations with vested interests in the FIM, and they may have used a different approach than the one we used in estimating completion time of an assessment instrument. For example, we do not know whether they measured only the time necessary to enter information on the FIM form or also included—(1) the time it took to obtain information from

the patient and/or clinical record; (2) the time it took to actually assess the patient; and (3) the time it took clinicians before filling out the FIM to apply clinical judgment, or to consult with other clinicians, or to examine the clinical record regarding their assessment observations. In addition, unlike the MDS–PAC estimates, the information from both external sources was survey information, instead of a controlled study. For the above reasons, when we conduct a test of the UDSmr, COS, and the MDS–PAC instruments we will include in the test measurements of the time it takes to complete each one.

Previously in this preamble we state that testing indicated that IRF staff familiar with the MDS–PAC can complete an update MDS–PAC in a median of 48 minutes. SNF staff familiar with the MDS–PAC can complete an update MDS–PAC in a median of 45 minutes.

Although we are proposing to require more items to be collected on an update assessment, the update assessment still requires less data collection than an initial assessment. Table 7C (found in section II of this preamble), entitled ''MDS–PAC Items Required by Type of Assessment,'' listed the items that we propose be collected on the Day 4 (admission), update (Day 11, Day 30, Day 60), and the discharge assessments. Counting the items in each column gives a simple total of the items required on each type of assessment. The update assessment requires that 85.2 percent of the items on the initial assessment be addressed on the update assessment. The discharge assessment requires that 87.5 percent of the items on the initial assessment be addressed on the discharge assessment. Consequently, we believe that the time required by IRF staff to complete an update MDS–PAC assessment is likely more than 48 minutes but less than the time it takes to complete the initial MDS–PAC assessment. We do not have data that specifically states the time it takes to complete a patient's discharge FIM, which, in essence, is the patient's update FIM. Therefore, we cannot currently compare MDS–PAC update or discharge assessment completion times to FIM update or discharge assessment completion times.

Most patients would require a Day 11 update assessment, because our data indicates that the mean length of stay is 15.81 days and the median length of stay is 14 days. Patients would also require a discharge assessment. But our data indicates that less than 9 percent of patients would require a Day 30 assessment, and less than ½ of one percent of patients would require a Day 60 assessment.

b. Start-Up Costs

The IRF's costs to start the MDS–PAC process consists of material costs and personnel costs. Our data indicates that in 1997 there were 1,123 IRFs. As presented in detail in Table 5G below entitled ''MDS–PAC IRF Start-up Costs'' we estimate that the costs for all IRFs to start the MDS–PAC process, excluding the MDS–PAC data collection costs discussed above, to be approximately $5,121,722 to $5,247,498, which is equal to approximately $4,561 to $4,673 per IRF.

The costs presented below are based on the profile of an average IRF, because certain costs are constant regardless of the size of the IRF. For both start-up costs and on-going costs, cost estimates are based on an assumption that IRFs would perform the encoding and transmission functions themselves.

TABLE 5G.—MDS–PAC IRF START-UP COSTS

Task/equipment	Hours per IRF	Cost per IRF	Estimated number of staff per IRF to be trained	Total per IRF	National costs
Hard drive, printer, RAM, MODEM, Internet Browser.		$0 [a]		$0 [a]	None
Training on MDS–PAC data collection at initial assessment, update assessment, discharge assessment, and data auditing.	16	PT [b] $27/hr; OT [b] $23/hr; RN [b] $20/hr	1 [c]	PT [d] $432; OT [e] $368; RN [f] $320	$359,360–$485,136 [g]
	12	$23/hr (average cost of the 3 disciplines)	9 [h]	$2,484 [i]	$2,789,532 [j]
Data Entry (encoding/transmission) training.	5.5	$12.50/hr [k]	1	$68.75 [l]	$77,206.25 [m]
Data Entry	96 [n]	$1,200 [o]		$1,200	$1,347,600 [p]
Data Entry Audits [q]		$38 [r]		$38	$42,674 [s]
Data Transmissions—Staff time.	1	$150 [t]		$150	$168,450 [u]
Running the data edit check program @ 20 minutes per month and actual transmission by staff @ 40 minutes per month.					
Systems Maintenance		$100		$100	$112,300
Supplies		$200		$200	$224,600
Total					$5,121,722–$5,247,498

[a] We believe that all IRFs have the computer capability to process the MDS–PAC-related software.

[b] These are the 1998 median hourly wages for these occupations based on the US Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000–2001 Edition.* We are providing a range of median hourly wages as the IRFs must determine the discipline specific clinician they will send to training.

[c] We expect the IRF to send a lead clinician to a HCFA sponsored training session and then that lead clinician would train the other IRF clinicians.

[d] 16 × $27.

[e] 16 × $23.

[f] 16 × $20.
[g] 1,123 × $320 to 1,123 × $432.
[h] This number represents the average number of clinicians per IRF that would require training. These clinicians would be trained in their facility.
[i] 12 hrs × $23/hr × 9 staff=$2,484.
[j] 1,123 × $2,484.
[k] We estimate that the hourly wage for data entry personnel is $12.50 per hour.
[l] 5.5 hrs × $12.50.
[m] 1,123 × $68.75.
[n] The average total of admissions per year per IRF is a approximately 320. We estimate that on average approximately 91 percent of IRF admissions will require 3 assessments. Approximately 9 percent of IRF admissions will require 4 assessments. This time includes data review and entry of 3 min. per assessment for up-front review & another 3 min. of post data entry review for a total of 6 min. 6 minutes × 291=1746 minutes/60=29.1 hrs × 3=87.3. 6 minutes × 29=174 minutes/60=2.9 hrs × 3=8.7 hrs. 87.3 + 8.7=96 hrs.
[o] We estimate an hourly rate for data entry costs of $12.50. 96 hrs × $12.50=$1200.
[p] 1,123 × $1200.
[q] We estimate a 15 minute monthly data entry audit for quality assurance purposes.
[r] $12.50 hr/4 × 12 months=$37.50 per year.
[s] 1,123 × $38.
[t] 1 hr × 12 (mos.) × $12.50/hr.
[u] 1,123 × $150.

Note: We anticipate that the IRFs will designate a lead licensed clinician to attend all training. That lead clinician would then provide training to other IRF staff.

(1) Computer Hardware and Software

Because we will supply to the IRFs free of charge the MDS–PAC software that performs the MDS–PAC process electronic functions, the IRFs will incur no software costs. We believe that IRFs possess the computer hardware capability to handle the MDS–PAC computerization, data transmission, and grouper software requirements. Our belief is based upon indications that—(1) Approximately 99 percent of hospital inpatient claims currently are submitted electronically; (2) close to 100 percent of IRFs submit their cost reports electronically; and (3) approximately 55 percent of IRFs submit FIMs electronically. Although we will supply the MPACT software, IRFs may incur costs, which we are not able to estimate, associated with making changes to their information management systems to incorporate the MPACT software. Therefore, we are specifically soliciting comments regarding MDS–PAC computerization issues.

IRFs have the option of purchasing data collection software that can be used to support other clinical or operational needs (for example, care planning, quality assurance, or billing) or other regulatory requirements for reporting patient information. However, we are developing an MDS–PAC data system (that is, MPACT) that would be available to IRFs at no charge through our website. MPACT would allow users to computerize their MDS–PAC assessment data and transmit the data in a HCFA-standard format to the HCFA MDS–PAC system. Therefore, IRFs that plan to use MPACT will need Internet access and a dial-up Internet Service Provider account in order to be able to download and install MPACT into their computer system. We believe that all IRFs currently have the capability to access the Internet. However, we are specifically soliciting comments from any IRFs that do not possess Internet access capability, in order for us to consider if we should make MPACT available to these facilities by some other means.

(2) Training

IRF staff will require training in performing MDS–PAC assessments, encoding assessments, preparing MDS–PAC data for electronic submission, and actually transmitting the data. We believe that the initial training of IRF personnel would require about 75.5 hours of staff time. We estimate training to cost an IRF approximately $1,242 for training of clinical staff, based on an average hourly payroll rate of $23 for licensed clinical staff. We estimate training to cost an IRF approximately $69 for training data entry staff, based on an average hourly payroll rate of $12.50 for data entry staff.

(3) Data Entry

IRFs have flexibility in choosing the data entry software used to computerize the MDS–PAC data, but the software must, at a minimum, perform the MPACT functions. In addition, when IRFs are performing data entry functions themselves, or contracting for the performance of these functions, the IRFs must ensure that performance of data entry complies with our requirement for safeguarding the confidentiality of clinical records.

IRFs must collect and transmit MDS–PAC data to the HCFA MDS–PAC system in accordance with the assessment schedule and transmission requirements specified elsewhere in this preamble. The data may be entered by an IRF staff member from a paper document completed by a licensed clinical staff member, or by a data entry operator under contract to the IRF to key in data. IRFs must allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the HCFA MDS–PAC system. We estimate that an average IRF will incur a cost of an hourly rate for data entry of $12.50. This cost includes data review and entry, as well as a (recommended) 15 minute monthly data entry audit for quality assurance purposes.

(4) Data Transmission

MDS–PAC data would be transmitted to the HCFA MDS–PAC system. This system is similar to the ones that HHAs use to report OASIS data and that SNFs use to report MDS 2.0 data. IRF staff must also manage the data transmission function, correct transmission problems, and manage report logs and validation reports transmitted by the HCFA MDS–PAC system. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program. This staff time will cost an average-sized IRF about $150 per year based on an hourly rate of $12.50. IRFs will be able to transmit the MDS–PAC data using the toll-free MDCN line.

(5) Systems Maintenance

There are costs associated with normal maintenance related to computer equipment, such as the replacement of disk drives or memory chips. Typically, this maintenance is provided through warranty agreements with the original equipment manufacturer, system retailer, or a firm that provides computer support. These maintenance costs are estimated to average no more than $100 per year IRF.

(6) Supplies

Supplies necessary for collection and transmission of data, including forms, diskettes, computer paper, and toner, will vary according to the size of the IRF, the number of patients served, and the number of assessments conducted.

We anticipate that an average IRF with approximately $200 in costs for supplies.

c. Ongoing Costs

We wanted to differentiate between one-time start-up costs for the IRF and costs we believe the IRFs will incur on a regular, yearly basis. Therefore, Table 6G entitled ''Agency Ongoing Costs'' include only data that we consider will be a repeated cost to the IRF.

TABLE 6G.—MDS–PAC IRF ONGOING COSTS

Task/equipment	Hours per IRF	Cost per IRF	Estimated number of staff	Total per IRF	National costs
Data Entry	96[a]	$1,200[b]		$1,200	$1,347,600[c]
Data Entry Audit(d)		$38[e]	1	$38	$42,674[f]
Data Transmissions—Staff time Running the data edit check program @ 20 minutes per month and actual transmission by staff @ 40 minutes per month.	1	$150[g]		$150	$168,450[h]
Systems Maintenance		$100		$100	$112,300
Supplies		$200		$200	$224,600
Annual Training:					
Clinical	12	$20–27/hr[i]	1	$240–$324[j]	$269,520–$363,852[k]
Data Entry	12	12.50/hr[l]	1	$150[m]	$168,450[n]
Clinical[o]	2	$20–27/hr.	9	$360–$486	$404,280–$545,778
Total					$2,737,874–$2,973,704

[a] The average total of admissions per year per IRF is approximately 320. We estimate that on average approximately 91 percent of IRF admissions will require 3 assessments. Approximately 9 percent of IRF admissions will require 4 assessments. This time includes data review and entry of 3 min. per assessment for up-front review & another 3 min. of post data entry review for a total of 6 min. 6 minutes × 291=1746 minutes/60=29.1 hrs × 3=87.3. 6 minutes × 29=174 minutes/60=2.9 hrs × 3=8.7 hrs. 87.3 + 8.7=96 hrs.

[b] We estimate an hourly rate for data entry costs of $12.50. 96 hrs × $12.50=$1,200.

[c] 1,123 × $1,200.

[d] We estimate a 15 minute monthly data entry audit for quality assurance purposes.

[e] $12.50 hr/4 × 12 months=$37.50 per year.

[f] 1,123 × $38.

[g] 1 hr × 12 (mos.) × $12.50/hr.

[h] 1,123 × $150.

[i] Based on the 1998 U.S. Dept. of Labor, Bureau of Labor Statistics, *Occupational Outlook Handbook, 2000–2001 Edition,* the median hourly wage for an RN is $20, $23 for an OT, and $27 for a PT. We are providing a range of median hourly wages as the IRFs must determine the discipline specific clinician they will send to training. We expect that the IRF will send one discipline specific clinician to a HCFA sponsored training session and then that individual would train the other IRF clinicians.

[j] 12 hours × $20 to 12 hours × $27.

[k] 1,123 × $240 to 1,123 × $324.

[l] We estimate that the hourly wage for data entry personnel is $12.50 per hour.

[m] 12 hours × $12.50.

[n] 1,123 × $150.

[o] This entry represents the average annual cost of IRF in-house training for the MDS–PAC.

Our data indicates that in 1997 there were 1,123 IRFs. Therefore, we estimate annual ongoing costs for an average-sized IRF, excluding MDS–PAC data collection costs discussed previously, to be approximately $2,438 to $2,648.

d. Conclusion

As discussed in detail above, IRFs will incur costs associated with the MDS–PAC process. Table 7G below is a further analysis of these costs.

TABLE 7G.—MDS–PAC COST PER CASE

[Based on IRFs currently completing a FIM instrument]

	Percent of MDS–PAC items completed	Maximum incremental clinician (physical therapist) cost per IRF (from table 4G)	Total incremental maximum cost per IRF (Col. 2 times Col. 3)	Average maximum incremental cost per case (Col. 4 divided by 320 average admissions per IRF)
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
Assessment Type:				
Initial	100.00	$9,424.18	$9,424.18	$29.45
Update	[1] 85.20	9,424.18	8,029.40	25.09
Discharge	[2] 87.50	9,424.18	8,246.16	25.77
Average Estimated Cost to Complete MDS–PAC	.....	.....	25,699.74	80.31
Estimated Maximum MDS–PAC Start-up Cost per IRF [3]	.....	.....	4,673.00	14.60
Total Estimated Maximum first year Cost	.....	.....	30,372.74	94.91

[1] Assumes the time to complete each MDS–PAC item weighted equally at 1.000.

[2] Same as footnote 1.

[3] This amount is based on the maximum costs shown in Table 5G divided by 1,123 IRFs. This amount will decline after the first year of implementation to reflect the ongoing costs shown in Table 6G.

We assessed the relationship between the estimated cost of completing the MDS–PAC with an estimate of the average cost of one RIC. For analysis we used RIC 7: Hip Fractures. This RIC has an estimated average cost of $9,848 (based upon secondary analysis of data from 1996 and 1997 MEDPAR and cost reports). We compared the assumed cost for completing the initial, update and discharge assessments using the MDS–PAC. We found that the average maximum incremental cost per case of completing the MDS–PAC for one year, assuming the completion of three assessments represents approximately 0.008 per cent of the cost of the estimated average cost of RIC 7. We used a single RIC for comparison because there is a large variation of cost across RICs. We believe that the estimated costs of completing the MDS–PAC are well justified when considered within the context of the statutory requirement and the methodology needed to implement the IRF prospective payment system, the probability that the MDS–PAC process will lead to increased quality of care for IRF patients, as well as the potential uses of the automated data by the IRFs themselves, the States, fiscal intermediaries, and HCFA. Our cost estimates may actually overstate anticipated costs, because they do not take into account cost-savings that IRFs may achieve by improving their management information systems, as well as potential improvements in the quality of patients' clinical care resulting from improved care planning under the MDS–PAC assessment process.

C. Alternatives Considered

We propose to use the MDS–PAC as the patient assessment instrument instead of the patient assessment instruments marketed by UDSmr or COS. These other patient assessment instruments are used by approximately 56 percent of the IRFs. But these patient assessment instruments are not as precise in assessing patients as the MDS–PAC, because they do not collect as much detailed data as the MDS–PAC. For example, the MDS–PAC provides a better description of a patient's cognitive functioning (the processing of empirical factual concepts) than these other assessment instruments. The MDS–PAC is also better at assessing a patient's mood and behavior patterns, measures of a patient's emotional and psychological status. Nor do these other assessment instruments allow for collecting patient assessment data in sufficient detail to allow us to develop the IRF quality of care monitoring system that we need. In addition, we believe that neither of these other patient assessment instruments permits a comparison of patients across different settings of post-acute care as recommended by MedPAC.

In constructing our proposed assessment schedule we decided not to use the patient assessment schedules associated with the patient assessment instruments marketed by UDSmr or COS. These other patient assessment instruments are used to assess patients only upon admission and discharge. We believe that the data provided by our update assessments would yield the type of structured data that we can use to monitor the quality of treatment being furnished. We also propose not to use the FIM items exactly as they are contained in the patient assessment instruments of UDSmr or COS, or the MDS–PAC with the FIM payment items pasted in exactly as contained in the patient assessment instruments of UDSmr or COS. These two approaches were not selected as they would not support HCFA's long-term quality monitoring strategy nor the goal to establish a common core post-acute care assessment instrument. In addition, we propose not to collect only the assessment items that would be used to generate a case-mix group determined payment rate, because these few items do not provide the scope of information needed to monitor access to care, quality of care, and to determine if future adjustments to the payment system are needed.

However, as we discussed earlier in the preamble, the process for arriving at the number of elements on the MDS–PAC was based on a consensus of clinical expert panels, which focused on the scope of elements necessary to support both quality monitoring and payment. Similarly, our proposed assessment schedule, including the number of assessments performed, was designed to meet both payment and quality monitoring objectives of the MDS–PAC. Alternatives to the approaches we have proposed in this rule could include either a reduction in the number of elements on the instrument or in the number of assessments performed while maintaining the MDS–PAC's ability to facilitate both payment and comprehensive quality monitoring. We are specifically requesting comments on these facets of the patient assessment methodology.

In accordance with the provisions of Executive Order 12866 this regulation was reviewed by the Office of Management and Budget.

IX. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506 (c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues for the sections that contain information collection requirements (ICRs).

Section 412.23 Excluded Hospitals: Classifications

- Paragraph (b)(2) requires that, except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, the entity show that during its most recent 12-month cost reporting period it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more specified conditions.
- Paragraph (b)(8) requires that a hospital seeking classification under this paragraph as a rehabilitation hospital, for the first 12-months cost reporting period that occurs after it becomes a Medicare participating hospital, may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this

section, instead of showing that it has treated this population during its most recent 12-month cost reporting period.

The information collection requirements of these two paragraphs of this section are currently approved under OMB approval number 0938–0358 (Psychiatric Unit Criteria Work Sheet, Rehabilitation Hospital Criteria Work Sheet, Rehabilitation Unit Criteria Work Sheet) through November 30, 2000. The proposed changes to the information collection requirements in these two paragraphs are clarifying changes.

Section 412.116 Method of Payment

Under 412.116 (b), *Periodic interim payments,* a hospital that meets the criteria in § 413.65(h) of this chapter may request in writing to receive periodic interim payments as described in this paragraph.

The burden associated with this provision is the time it takes a hospital to write its request for periodic interim payments. We estimate that 34 facilities would request these payments and that it would take each 1 hour to write and mail its request.

Sections 412.606 Patient Assessment and 412.610(c) Assessment Schedule

• Paragraph (a) of § 412.606 requires that at the time each Medicare patient is admitted the facility must have physician orders for the patient's immediate care.

This requirement is subject to the PRA. However, we believe that the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2), because the time, effort, and financial resources necessary to comply with the requirement are incurred by persons in the normal course of their activities.

• Paragraph (c) of § 412.606, *Comprehensive assessments,* requires that an IRF clinician initially and periodically perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare patient using the MDS–PAC as the patient assessment instrument and that the assessment process must include—

• Direct patient observation and communication with the patient; and

• When appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, and the patient's clinical record and other sources.

• Section 412.610(c), *Assessment reference dates,* requires assessments upon admission (Day 4); Day 11, Day 30, and Day 60; upon discharge or when the patient stops receiving part A benefits.

In 1997, there were approxiamtely 359,000 admissions to IRFs and there are 1,123 facilities, averaging 320 admissions annually. We estimate that it would take 85 minutes for the initial assessment and at least 48 minutes for each subsequent assessment.

Under these proposed rules, all Medicare beneficiaries would be assessed two times: upon admission and upon discharge. Sixty-six percent would be assessed on the 11th day as well. Fewer than 9 percent of Medicare beneficiaries in IRFs would also be assessed at 30 days. Fewer than ½ of a percent would require an assessment at 60 days.

Below is a chart showing burden.

Type of assessment	Estimated time for completion (in minutes)	Hours per year per facility (in hours)	Hours per year nationwide (in hours)
Admission (Day 4)	85	453	508,719
Day 11	48	169	189,787
Day 30	48	23	25,829
Day 60	48	1	1,123
Discharge	48	256	287,488
Total/Facility (5 assessment)		902	1,012,946

The total ongoing annual burden for all facilities for five assessments would be 902 hours × 1,123 or 1,012,946 hours.

We are also including training in our burden estimates: 16 hours to train the lead clinician and 12 hours to train the other clinicians (an average of 9). This totals 121,284 nationally for a one-time burden. We also estimate an on-going burden for training of 14 hours per IRF per year (15,722 nationally).

Section 412.608 Patient Rights Regarding MDS–PAC Data Collection.

Under paragraph (a) of this section, before performing an assessment of a Medicare inpatient using the MDS–PAC, an IRF clinician must inform the Medicare inpatient of the following patient rights:

• The right to be informed of the purpose of the MDS–PAC data collection;

• The right to have the MDS–PAC information collected kept confidential and secure;

• The right to be informed that the MDS–PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

• The right to refuse to answer MDS–PAC questions; and

• The right to see, review, and request changes on his or her MDS–PAC assessment.

Under paragraph (b) of this section, the IRF must ensure that the authorized clinician document in the patient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

In accordance with paragraph (c) of this section, the patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13.

We anticipate adding the burden of disclosure to IRF patients and documenting that disclosure to the burden in § 412.13 on hospitals furnishing a patient rights statements. The hospitals would be able to easily give both statements to patients upon admission, along with other required notifications. The burden for the general patient rights statement has not yet been approved but is under development. We have estimated that it would take each hospital 5 minutes to disclose the general hospital statement to each patient on admission. The disclosure of the IRF patients' rights statement would increase that time by an estimated 2 minutes.

Section 412.610 Assessment Schedule

Paragraph (g), *MDS–PAC record retention,* of this section requires that an IRF maintain all MDS–PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

We estimate that, for facilities that choose to file a paper copy, it would

take the facility 5 minutes to print out, or copy, each assessment and file it in the patient's record. On average, each facility would need to obtain a copy of and file 882 assessments per year, equaling 74 hours. We cannot estimate how many facilities would choose to file paper copies. However, we are assuming that most facilities would choose to retain the assessments in an electronic format, which would not add to the paperwork burden. We request comments on the accuracy of this assumption concerning how many facilities will comply by retaining an electronic version.

Section 412.612 Coordination of MDS–PAC Data Collection.

Paragraph (b), *Certification,* of this section requires that the authorized clinician who has done at least part of the assessment certify the accuracy and completion date by signing and dating the appropriate lines of section AB of the MDS–PAC.

We estimate that it would take the authorized clinician approximately 10 minutes per assessment to determine to his or her satisfaction that the assessment is complete and to so certify. Eight hundred eighty-two assessments would equal 147 hours per year per facility, and 165,081 hours nationally.

Paragraph (c) of this section requires that any clinical who contributes data for an MDS–PAC item sign and date the appropriate lines of the MDS–PAC.

Under the definition of information in 5 CFR 1320.3(h)(1), ''information'' does not include such items as affidavits, oaths, affirmations, certifications, consents or acknowledgments, provided that they do not entail any burden other than that necessary to identify the respondent, the date, and the respondent's address. We believe that the signatures required by § 412.610(c) are acknowledgments identifying the signers (as persons furnishing a service) and are not information.

Section 412.614 Transmission of MDS–PAC Data

Paragraph (a), *Data format,* of this section requires that each IRF encode and transmit data—

- Using the computer program(s) available from HCFA; or
- Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS–PAC data set, and meets other HCFA specifications.

In accordance with paragraph (b), *How to transmit data,* of this section, each IRF must—

- Electronically transmit complete and encoded MDS–PAC data for each Medicare inpatient to the HCFA MDS–PAC system in accordance with the data format specified in paragraph (a) of this section; and
- Transmit data using electronic communications software that provides a direct telephone connection from the IRF to the HCFA MDS–PAC system.

IRFs would have to collect and transmit MDS–PAC data to the HCFA MDS—PAC system. The data may be entered by a IRF staff member from a paper document completed by a licensed clinical staff member, or by a data entry operator under contract to the IRF to key in data. IRFs would have to allow time for data validation, preparation of data for transmission, and correction of returned records that failed checks by the HCFA MDS–PAC system.

We estimate that an average IRF with 320 admissions per year will require 3 minutes for data review and entry per assessment for up-front review and another 3 minutes for data entry review for a total of 6 minutes. The burden of transmitting the data is contained in that 6 minutes. The yearly burden would be 96 hours per facility. (This burden also includes recommended 15 minute monthly data entry audit for quality assurance purposes.)

Other Data Transmission Functions

In addition to the burden of managing the data transmission function, IRF staff will have to correct transmission problems and manage report logs and validation reports transmitted by the HCFA MDS–PAC system. We estimate that it will take about one additional hour of staff time to perform data transmission related tasks each month, including running a data edit check program.

We estimate that it will require a one-time burden of 5.5 hours per hospital to train the personnel to be able to complete data transmission tasks. With 1,123 facilities, the national burden would be 6177 hours.

Section 412.616 Release of Information Collected Using the MDS–PAC

Under paragraph (b) of this section, a facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and to the extent the facility itself is permitted to do so under § 412.616(a).

The burden associated with this ICR is the time required to include the necessary information in the contract. While this ICR is subject to the PRA, we believe the burden associated with it is exempt as defined in 5 CFR 1320.3(b)(2) because the time, effort, and financial resources necessary to comply with the requirement would be incurred by persons in the normal course of their activities.

Section 412.618 Interrupted Stay

Paragraph (a) of this section requires that if a patient has an interrupted stay the facility must record interrupted stay data on the MDS–PAC interrupted stay tracking form.

We currently have no data on the incidence of interrupted stays. We estimate, however, that it would take no more than 5 minutes to complete a form. We request comments on the burden that completion of this form might impose.

Submission to OMB

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements in §§ 412.23, 412.29, 412.116, and 412.606 through 412.618. These requirements are not effective until they have been approved by OMB.

If you have any comments on any of these information collection and record keeping requirements, please mail the original and 3 copies directly to the following:

Health Care Financing Administration, Office of Information Services, Standards and Security Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: Julie Brown HCFA–1069–P.

and,

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Allison Eydt, HCFA Desk Officer.

List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is proposed to be amended as follows:

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. Section § 412.1 is revised to read as follows:

§ 412.1 Scope of part.

(a) *Purpose.* (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in § 412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with § 413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meets the conditions of § 412.604.

(b) *Summary of content.* (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after April 1, 2001.

Subpart B—Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

A. Revising paragraph (a).

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising the introductory text of the redesignated paragraph (c).

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b) and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after April 1, 2001, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

* * * * *

4. Section 412.22 is amended by:

A. Revising paragraphs (a) and (b).

B. Revising the introductory text of paragraph (e).

C. Revising the introductory text of paragraph (h)(2).

§ 412.22 Excluded hospitals and hospital units: General rules.

(a) *Criteria.* Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified

in § 412.1(a)(1) of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) *Cost reimbursement.* Except for those hospitals specified in paragraph (c) of this section and § 412.20(b), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

* * * * *

(e) *Hospitals within hospitals.* Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(h) *Satellite facilities.* * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite facility must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

5. Section 412.23 is amended by:

A. Revising the introductory text.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs (b)(2) introductory text, (b)(8), and (b)(9).

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(b) *Rehabilitation hospitals.* A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2):

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital's regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) or is paid under the prospective payment system specified in § 412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, HCFA adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130.

* * * * *

6. In § 412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§ 412.25 Excluded hospital units: Common requirements.

(a) *Basis for exclusion.* In order to be excluded from the prospective payment systems specified in § 412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) *Satellite facilities.* * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

7. In § 412.29, the introductory text is revised to read as follows:

§ 412.29 Excluded rehabilitation units: Additional requirements.

In order to be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H—Payments to Hospitals Under the Prospective Payment Systems

8. In § 412.116, paragraph (a) is revised to read as follows:

§ 412.116 Method of payment.

(a) *General rule.* (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before April 1, 2001) are made as described in § 413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after April 1, 2001, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of § 412.604 are made as described in § 412.632.

* * * * *

9. In § 412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§ 412.130 Retroactive adjustments for incorrectly excluded hospitals and units.

(a) *Hospitals for which adjustment is made.* * * *

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system

specified in § 412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

* * * * *

(b) *Adjustment of payment.* (1) For cost reporting periods beginning before April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital based on the exclusion and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

(2) For cost reporting periods beginning on or after April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

Subparts N and O—[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§ 412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612, 412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632 is added to read as follows:

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

Sec.

Subpart P—Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

§ 412.600 Basis and scope of subpart.

(a) *Basis.* This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as ''inpatient rehabilitation facilities'').

(b) *Scope.* This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after April 1, 2001, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities is made on the basis of prospectively determined rates and applied on a per discharge basis.

§ 412.602 Definitions.

As used in this subpart—

Assessment reference date means the specific calendar day in the MDS–PAC assessment process that sets the designated endpoint of the common 3 day patient observation period, with most MDS–PAC assessment items usually referring back in time from this endpoint.

Authorized clinician means one of the following clinicians:

(1) An occupational therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(2) A physical therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(3) A physician who is a doctor of medicine or osteopathy and is licensed to practice medicine and surgery by the State in which the function or action is performed.

(4) A registered nurse as defined in § 484.4 of this chapter.

Discharge A Medicare patient in a inpatient rehabilitation facility is considered discharged when—

(1) The patient is formally released; or

(2) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized MDS–PAC software program.

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means the period during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of discharge.

MDS–PAC stands for the Minimum Data Set for Post Acute Care, a patient clinical assessment instrument.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Rural area means an area as defined in § 412.62(f)(1)(iii).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means an area as defined in § 412.62(f)(1)(ii).

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) *General requirements.* (1) An inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, HCFA may, as appropriate—

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) *Inpatient rehabilitation facilities subject to the prospective payment system.* An inpatient rehabilitation facility must meet the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment systems specified in § 412.1(a)(1).

(c) *Completion of patient assessment instrument.* For each Medicare patient admitted or discharged on or after April 1, 2001, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606.

(d) *Limitation on charges to beneficiaries.* (1) *Prohibited charges.* Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) *Permitted charges.* An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter.

(e) *Furnishing of inpatient hospital services directly or under arrangement.* (1) The applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter, other than physicians' services to individual patients reimbursable on a reasonable cost basis (in accordance with the criteria of § 415.102(a) of this subchapter).

(2) HCFA does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b) of this chapter and services of an anesthetist employed by a physician reimbursable under § 415.102(a) of this subchapter.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in § 409.3 of this subchapter).

(f) *Reporting and recordkeeping requirements.* All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

§ 412.606 Patient assessment.

(a) *Admission orders.* At the time that each Medicare patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) *Patient assessment instrument.* An inpatient rehabilitation facility must use the MDS–PAC instrument to assess Medicare inpatients who—

(1) Are admitted on or after April 1, 2001; or

(2) Were admitted before April 1, 2001, and are still inpatients as of April 1, 2001.

(c) *Comprehensive assessments.* (1) An inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS–PAC as part of his or her patient assessment in accordance with the schedule described in § 412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility must record appropriate and applicable data accurately and completely for each MDS–PAC item.

(3) The assessment process must include—

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, the patient's clinical record, and other sources.

(4) The authorized clinician, must sign the MDS–PAC attesting to its completion and accuracy.

§ 412.608 Patient rights regarding MDS–PAC data collection.

(a) Before performing an assessment using the MDS–PAC, an authorized clinician must inform the Medicare inpatient of the following patient rights:

(1) The right to be informed of the purpose of the MDS–PAC data collection;

(2) The right to have the MDS–PAC information collected be kept confidential and secure;

(3) The right to be informed that the MDS–PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer MDS–PAC questions; and

(5) The right to see, review, and request changes on his or her MDS–PAC assessment.

(b) The inpatient rehabilitation facility must ensure that an authorized clinician documents in the Medicare inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13 of this chapter.

§ 412.610 Assessment schedule.

(a) *General.* For each Medicare inpatient an inpatient rehabilitation facility must submit MDS–PAC assessment data that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) *Starting the assessment schedule day count.* The first day that the inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the MDS–PAC assessment schedule.

(c) *Assessment reference dates.* With respect to the patient's current hospitalization, an inpatient rehabilitation facility must indicate on the MDS–PAC one of the following assessment reference dates:

(1) *Day 4 MDS–PAC assessment.* For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization, the date that is the 3rd calendar day after the patient started being furnished Medicare-covered Part A services.

(2) *Day 11 MDS–PAC assessment.* For the assessment that covers calendar days 8 through 10 of the patient's current hospitalization, the date that is the 10th calendar day after the patient started being furnished Medicare-covered Part A services.

(3) *Day 30 MDS–PAC assessment.* For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization, the date that is the 30th calendar day after the patient

started being furnished Medicare-covered Part A services.

(4) *Day 60 MDS–PAC assessment.* For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization, the date that is the 60th calendar day after the patient started being furnished Medicare-covered Part A services.

(5) *Discontinuation of Medicare-covered Part A services assessment.* For the assessment that is completed when the inpatient is not discharged from the inpatient rehabilitation facility but stops receiving Medicare-covered Part A services, the actual date that the inpatient stops receiving Medicare-covered Part A services.

(6) *Discharge assessment.* For the assessment that is completed when the Medicare inpatient is discharged from the inpatient rehabilitation facility, the actual date of discharge from the inpatient rehabilitation facility.

(d) *Late MDS–PAC assessment reference date.* If the MDS–PAC assessment reference date is entered later than the assessment reference date specified in paragraph (c)(1) of this section, the MDS–PAC assessment reference date is considered late.

(1) If the MDS–PAC assessment reference date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(2) If the MDS–PAC assessment reference date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

(e) *Completion and encoding dates.* (1) The Day 4, Day 11, Day 30, and Day 60 MDS–PAC assessments must be completed 1 calendar day after the MDS–PAC assessment reference date that is recorded on the MDS–PAC.

(2) The discharge MDS–PAC assessment must be completed on the 5th calendar day in the period beginning with the MDS–PAC assessment reference date.

(3) All MDS–PAC assessments must be encoded by the 7th calendar day in the period beginning with the MDS–PAC completion date that is recorded on the MDS–PAC.

(f) *Accuracy of the MDS–PAC data.* The encoded MDS–PAC assessment data must accurately reflect the patient's clinical status at the time of the MDS–PAC assessment.

(g) *MDS–PAC record retention.* An inpatient rehabilitation facility must maintain all MDS–PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

§ 412.612 Coordination of MDS–PAC data collection.

(a) *Responsibilities of the authorized clinician.* An inpatient rehabilitation facility's authorized clinician who has participated in performing an MDS–PAC patient assessment must have responsibility for—

(1) The accuracy and thoroughness of the patient's MDS–PAC assessment; and

(2) The accuracy of the date inserted in the attestation section of the MDS–PAC.

(b) *Certification.* An inpatient rehabilitation facility's authorized clinician must certify the accuracy and completion date of the MDS–PAC assessment by signing and dating the appropriate lines of the MDS–PAC.

(c) *Signatures.* Any clinician who contributes data for an MDS–PAC item must sign and date the appropriate lines of the MDS–PAC.

(d) *Penalty for falsification.* (1) Under Medicare an individual who knowingly and willfully—

(i) Certifies a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§ 412.614 Transmission of MDS–PAC data.

(a) *Data format.* The inpatient rehabilitation facility must encode and transmit data for each Medicare inpatient—

(1) Using the computerized version of the MDS–PAC available from HCFA; or (2) Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS–PAC data set, and meets other HCFA specifications.

(b) *How to transmit data.* The inpatient rehabilitation facility must—

(1) Electronically transmit complete and encoded MDS–PAC data for each Medicare inpatient to the HCFA MDS–PAC system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the HCFA MDS–PAC system.

(c) *Transmission dates.* All MDS–PAC assessments must be transmitted to HCFA MDS–PAC system by the 7th calendar day in the period beginning with the last permitted MDS–PAC encoding date.

(d) *Late transmission penalty.* (1) HCFA assesses a penalty when an inpatient rehabilitation facility does not transmit the required MDS–PAC data to the HCFA MDS–PAC system in accordance with the transmission timeframe in paragraph (c) of this section.

(2) If the actual MDS–PAC transmission date is later than the transmission date specified in paragraph (a) of this section the MDS–PAC data is considered late.

(i) If the MDS–PAC transmission date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(ii) If the MDS–PAC transmission date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

§ 412.616 Release of information collected using the MDS–PAC.

(a) *General.* An inpatient rehabilitation facility may release information from the MDS–PAC only as specified in § 482.24(b)(3) of this chapter.

(b) *Release to the inpatient rehabilitation facility's agent.* An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§ 412.618 Interrupted stay.

For purposes of the MDS–PAC assessment process, if a Medicare patient has an interrupted stay the following applies:

(a) *Assessment requirements.* (1) The initial case-mix group classification from the Day 4 MDS–PAC assessment remains in effect (that is, no new Day 4 MDS–PAC assessment is performed).

(2) The required scheduled MDS–PAC Day 11, Day 30, and Day 60 assessments must be performed.

(3) When the patient is discharged, a discharge MDS–PAC assessment must be performed.

(b) *Recording and encoding of data.* The authorized clinician must record

the interrupted stay data on the interrupted stay tracking form of the MDS–PAC.

(c) *Transmission of data.* The data recorded on the interrupted stay tracking form must be transmitted to the HCFA MDS–PAC system within 7 calendar days of the date that the Medicare patient returns to the inpatient rehabilitation facility.

(d) *Revised assessment schedule.* (1) If the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission dates for the Day 4 and Day 11 MDS–PAC assessments are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(2) If the interrupted stay occurs after the Day 4 assessment and before the Day 11 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 11 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(3) If the interrupted stay occurs after the Day 11 and before the Day 30 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 30 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(4) If the interrupted stay occurs after the Day 30 and before the Day 60 assessment then the assessment reference date, completion date, encoding date, and data transmission date for the Day 60 MDS–PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

§ 412.620 Patient classification system.

(a) *Classification methodology.* (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For the purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from Day 4 assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(b) *Weighting factors.* (1) *General.* An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) *Short-stay outliers.* HCFA will determine a weighting factor or factors for patients that are discharged and not transferred within a number of days from admission as specified by HCFA.

(3) *Patients who expire.* HCFA will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by HCFA.

(c) *Revision of case-mix group classifications and weighting factors.* HCFA may periodically adjust the case-mix groups and weighting factors to reflect changes in—

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) *Method of payment.* (1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) *Payment in full.* (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following—

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter, and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) *Data used.* To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities HCFA uses—

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, used to estimate payments for inpatient operating and capital costs made under part 413 under this subchapter;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and other data that account for the relative resource utilization of different patient types.

(b) *Determining the average costs per discharge for fiscal year 2000.* HCFA determines the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2000 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2000.

(c) *Determining the Federal prospective payment rates*—(1) *General.* The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments and other adjustments.

(2) *Update the cost per discharge.* (i) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to compute the cost per discharge for fiscal year 2001. Based on the updated cost per discharge, HCFA estimates the payments that would have been made to the facility for fiscal year 2001 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(ii) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's fiscal year 2001 cost per discharge determined under paragraph (c)(2)(i) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, HCFA estimates the

payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) *Computation of the budget neutral conversion factor.* The budget neutral conversion factor is computed as follows:

(i) *For fiscal years 2001 and 2002.* Based on the updated costs per discharge and estimated payments for fiscal years 2001 and 2002 determined in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, HCFA computes a budget neutral conversion factor for fiscal years 2001 and 2002, as specified by HCFA, that reflects, as appropriate, the adjustments described in paragraph (d) of this section.

(ii) *For fiscal years after 2002.* The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section including adjustments, described in paragraph (d) of this section, as appropriate.

(4) *Determining the Federal prospective payment rate for each case-mix group.* The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) *Adjustments to the budget neutral conversion factor.* The budget neutral conversion factor described in paragraph (c)(3) of this section will be adjusted for—

(1) *Outlier payments.* HCFA determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) *Budget neutrality.* HCFA adjusts the Federal prospective payment rates for fiscal years 2001 and 2002 so that aggregate payments under the prospective payment system are estimated to equal 98 percent of the amount that would have been made to inpatient rehabilitation facilities under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.

(3) *Coding and classification changes.* HCFA adjusts the budget neutral conversion factor for a given year if HCFA determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) *Calculation of the adjusted Federal prospective payment.* For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate determined under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) *Adjustment for area wage levels.* The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(2) *Adjustments for low income patients.* HCFA adjusts the Federal prospective payment, on a facility basis, for the proportion of low income patients that receive inpatient rehabilitation services as determined by HCFA.

(3) *Adjustments for rural areas.* HCFA adjusts the Federal prospective payment by a factor, as specified by HCFA, to account for the higher costs per patient in facilities located in rural areas as defined in § 412.602.

(4) *Adjustment for high cost outliers.* HCFA provides for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels, and factors to account for treating low income patients and for rural locations) as specified by HCFA. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount.

(5) *Adjustments related to the MDS–PAC.* An adjustment to a facility's Federal prospective payment amount for a given discharge will be made if—

(i) The assessment reference date identified on the MDS–PAC as described in § 412.610(d) is late; and

(ii) The transmission of MDS–PAC data as described in § 412.614(d) is late.

(f) *Special payment provision for patients that are transferred.* (1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who—

(i) Is transferred from the inpatient rehabilitation facility to another site of care,; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for non-transfer cases in the case-mix group to which the patient is classified.

(2) HCFA calculates the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for non-transfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the unadjusted payment amount.

(iii) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(ii) of this section.

§ 412.626 Transition period.

(a) *Duration of transition period and proportions of the blended transition rate.* (1) For cost reporting periods beginning on or after April 1, 2001 through fiscal year 2002, inpatient rehabilitation facilities receive a payment comprised of a blend of the adjusted Federal prospective payment, as determined in § 412.624(e) or § 412.624(f) and, a facility-specific payment as determined in paragraph (b) of this section.

(i) For cost reporting periods beginning on or after April 1, 2001 and before fiscal year 2002, payment is based on 66⅔ percent of the facility-specific payment and 33⅓ percent of the adjusted Federal prospective payment.

(ii) For cost reporting periods beginning in fiscal year 2002, payment is based on 33⅓ percent of the facility-specific payment and 66⅔ percent of the adjusted Federal prospective payment.

(2) For cost reporting periods beginning with fiscal year 2003 and after, payment is based entirely on the adjusted Federal prospective payment.

(b) *Calculation of the facility-specific payment.* The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

§ 412.628 Publication of the Federal prospective payment rates.

HCFA publishes information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge payment rates, additional payments for outliers and special payments, and the area wage index.

§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) *General rule.* Subject to the exceptions in paragraphs (b) and (c) of this section, inpatient rehabilitation facilities receive payment under this subpart for inpatient operating costs and capital costs for each discharge only following submission of a discharge bill.

(b) *Periodic interim payments.* (1) *Criteria for receiving periodic interim payments.* (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the PIP method without undue risk of its resulting in an overpayment to the provider.

(2) *Frequency of payment.* For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) *Termination of PIP*—(i) *Request by the inpatient rehabilitation facility.* Subject to paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments on a non-PIP basis at any time.

(ii) *Removal by the intermediary.* An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) *Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system.* For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) *Outlier payments.* Additional payments for outliers are not made on an interim basis. The outlier payments are made based on the submission of a discharge bill and represent final payment.

(e) *Accelerated payments*—(1) *General rule.* Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) *Approval of payment.* An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and HCFA.

(3) *Amount of payment.* The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) *Recovery of payment.* Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

2. Section 413.1 is amended by:

A. Revising paragraph (d)(2)(ii).

B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§ 413.1 Introduction.

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part 412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable

cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of § 412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C—Limits on Cost Reimbursement

3. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (a)(2)(i).

B. Adding a new paragraph (a)(2)(i)(C).

C. Revising paragraph (a)(2)(ii).

D. Adding paragraph (a)(2)(iii).

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) *Introduction.* * * *

(2) *Applicability.* (i) This section is not applicable to—

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after October 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to—

(A) Hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in § 412.1(a)(1) of this chapter and in accordance with §§ 412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified in §§ 412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before April 1, 2001, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter.

* * * * *

Subpart E—Payments to Providers

4. In § 413.64 paragraph (h)(2)(i) is revised to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) *Periodic interim payment method of reimbursement*—* * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in § 412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: September 18, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: September 29, 2000.

Donna E. Shalala,

Secretary.

Note: The following appendices will not appear in the Code of Federal Regulations.

Appendix A—Technical Discussion of Cases and Providers Used in RAND Analysis

This Appendix explains the methodology used to create the data file used to develop the proposed IRF prospective payment system. A general description of the process to create this data file is contained in section II of this proposed rule. RAND has performed the following analysis to match UDSmr, COS, and HCFA data files.

Table A shows that for 1996 and 1997, the MEDPAR files had over 12 million records per year. We are interested in a subset of these records: cases paid by Medicare as rehabilitation stays that were exempt from the acute care hospital PPS.

TABLE A.—NUMBER OF MEDPAR CASES AND FACILITIES

Calendar year	No. of cases	No. of facilities
1996	12,231,275	6,339
1997	12,263,463	6,257

Table B shows total 1996 and 1997 rehabilitation stays by type of provider (free-standing rehabilitation facility versus excluded unit of an acute care hospital). This was the ''sampling'' frame. In order to describe the IRF prospective payment system case-mix, RAND attached information from FIM instruments to each record in this frame, thereby obtaining ''complete'' records. To the extent that RAND was unable to add information to some records, it was important to know both how to and whether to weight the complete records so they would reflect the composition of the frame.

TABLE B.—NUMBER OF REHABILITATION MEDPAR CASES AND FACILITIES

Calendar year/type	No. of cases	No. of facilities
1996:		
Excluded unit	229,193	877
Free-standing	114,933	204
Total	344,126	1,081
1997:		
Excluded unit	240,491	911
Free-standing	118,541	212
Total	359,032	1,123

Note: Free-standing facilities have characters 3–6 of the Medicare provider number in the range 3025–3099. Patients receiving rehabilitation care in excluded units of acute care hospitals have a ''provider code'' of T in their MEDPAR records.

Table C shows the number of facilities and the number of UDSmr and COS records for calendar years 1996 and 1997.

TABLE C.—NUMBER OF UDSMR/COS RECORDS AND FACILITIES

Calendar year	Source	No. of records	No. of facilities
1996	UDSmr	225,069	533
	COS	44,478	159
1997	UDSmr	258,915	595
	COS	67,350	164

Matching MEDPAR and UDSmr/COS Facilities

The first step in the matching process is to link MEDPAR facilities to UDSmr/COS facilities. For each of these combinations, RAND counted the number of exact matches of MEDPAR and UDSmr/COS records based on admission date, discharge date, and zip code. Table D summarizes the results of this stage of the linking process. The number of facilities represented in our UDSmr/COS datasets is slightly more than half of all IRFs.

TABLE D.—NUMBERS OF UDSMR/COS FACILITIES LINKED TO MEDPAR FACILITIES

Calendar year/source	MEDPAR Unique [1]	MEDPAR Multiple [2]	Non-Rehab [3]	Total
1996:				
UDSmr	501	10	22	533
COS	67	8	84	159
1997:				
UDSmr	557	15	23	595
COS	68	18	78	164

[1] UDSmr/COS IRFs that appear to have a single MEDPAR provider.
[2] UDSmr/COS IRFs that appear to have more than one MEDPAR provider.
[3] UDSmr/COS IRFs that appear to be SNFs or long term care hospitals.

The UDSmr/COS data do not contain the Medicare beneficiary identifier, and therefore it was necessary to use a probabilistic matching algorithm based on characteristics of the beneficiary and the hospitalization. The matching was accomplished in a series of four steps:

(1) Identify match variables;

(2) Recode certain UDSmr/COS variables to be consistent with MEDPAR, create additional records for UDSmr interrupted stays, and eliminate duplicate cases;

(3) Run a match algorithm to link UDSmr/COS and MEDPAR records; and

(4) Choose a single MEDPAR case if it matches multiple UDSmr or COS cases.

Step 1: Identify Match Variables

A further search for matches only within the provider number and facility identifier pairings was performed. For free-standing facilities, an attempt was made to match all MEDPAR records to a UDSmr record.

For MEDPAR, in addition to facility identity, 6 variables were used to link the records: Admission date, discharge date, zip code, age at admission, sex, and race. For UDSmr/COS, the same information in a slightly recoded form was available (for example, birth date). An indicator of whether Medicare was the primary payor was used to determine how to set certain parameters for the matching algorithm.

Step 2: Create Additional UDSmr/COS Files

COS's coding of interrupted stays is similar to Medicare's: One record per rehabilitation episode; therefore, these records did not require any additional processing. UDSmr, however, codes multiple stays via a series of ''transfer/return'' dates on a single UDSmr record. To facilitate matching UDSmr and MEDPAR records, multiple records for interrupted stays were created with admission and discharge dates corresponding to the beginning and ending of each stay. The additional records were then given the same chance of matching MEDPAR records as any non-interrupted stay. For both UDSmr and COS files, there were some duplicate cases.

Table E shows the number of records present at the various stages of processing. The last column shows the number of cases that would be matched to MEDPAR.

TABLE E.—NUMBER OF UDSMR/COS RECORDS AT VARIOUS STAGES OF PROCESSING

Calendar year/source	No. of records		
	Original	After expansion	After duplicate elimination
1996:			
UDSmr	225,069	232,076	231,003
COS	44,478	44,478	44,375
1997:			
UDSmr	258,915	267,444	266,288
COS	67,350	67,350	67,082

Step 3: Match Discharges from MEDPAR and UDSmr/CareData

A match algorithm similar to the one used in Carter, Relles, et al. (1997) was run assuming that links are imperfect—any variable can be in error. A scoring function is developed, based on Bayes' Theorem, which gives the odds of a match based on how consistent variables tend to be for true matching and non-matching cases. A score of 2.00 or above has a high probability of identifying a match. The match statistics reported below assume that cutoff.

Step 4: Choose a Single MEDPAR Case for Multiple UDSmr/COS Matches

While the matching was unique within a facility/provider pair, some MEDPAR providers were paired with different facilities, as shown in Table F. Also, some UDSmr and COS facilities were the same: 6 overlaps in 1996, 7 in 1997.

TABLE F.—MEDPAR FACILITIES PAIRED WITH MULTIPLE FACILITIES

Source	Calendar year	No. of facilities
UDSmr	1996	5
UDSmr	1997	8
COS	1996	5
COS	1997	10

First, MEDPAR duplicate links were eliminated within each file, and then duplicate links were eliminated between UDSmr and COS files all within the same years. In all cases, the highest scores were kept. Table G provides results for cutoff score 2.0.

TABLE G.—NUMBER OF LINKED RECORDS AFTER DUPLICATION ELIMINATION

Calendar year/source	No. of Records, Cutoff Source ≥2.0			
	Multiple paired providers (a)	Total records	Duplicates eliminated (b)	Overlap eliminated (c)
1996:				
UDSmr	5	163,509	162,850	162,692
COS	5	27,664	27,630	26,197
1997:				
UDSmr	8	185,567	184,431	183,960
COS	10	42,219	41,980	38,722

Note: (a) Number of MEDPAR providers paired with more than one UDSmr/COS facility. (b) Multiple pairings can link the same MEDPAR record to more than one UDSmr/COS case. This step eliminates those multiple links, keeping the link with the highest match score. (c) the same MEDPAR provider might show up in both UDSmr and COS, again allowing the same MEDPAR record to match more than one UDSmr/COS case.

Quality of the Match

There are two aspects to evaluating the quality of the match. The first is whether we actually matched all of the cases. To evaluate this, we computed match rates for each of our populations: UDSmr, COS, and MEDPAR. The second aspect is the representativeness of the match for the entire population. To evaluate this, we compared patient and facility characteristics to both linked and full population, and considered whether some form of weighting would make those populations look sufficiently the same.

Match Rates

Table H suggests overall match rates in these UDSmr/COS facilities for the eligible RPPS population to be almost 90 percent. This was slightly higher than expected—the Carter, Relles, *et al.* (1997) match rates were about 86 percent.

TABLE H.—MEDPAR MATCH RATES, PROVIDERS WITH A FULL YEAR OF DATA

Source	Calendar year	MEDPAR cases	Matched cases	Percent matched
UDSmr	1996	155,502	136,056	87.5
UDSmr	1997	175,807	156,520	89.0
COS	1996	7,157	6,354	88.8
COS	1997	36,774	33,549	91.2

Note: Tabulations are for patients eligible for IRFPPS.

The UDSmr/COS.com files contain many cases not paid by Medicare, but the files provide an indication of whether Medicare is the primary payer. Restricting our attention to just these cases, we obtain the percentages shown in Table I.

TABLE I.—UDSMR/COS MATCH RATES FOR MEDICARE AS THE PRIMARY PAYER

Source	Calendar year	UDS/COS cases	Matched cases	Percent matched
UDSmr	1996	160,125	153,926	96.1
UDSmr	1997	179,179	171,885	95.9
COS	1996	28,767	26,857	93.4
COS	1997	44,172	41,168	93.2

Note: UDSmr/COS cases matching any Medicare case.

These match rates are also slightly higher than reported in Carter and Relles (1997), where a 93.7 percent rate was achieved for 1994 UDSmr data. We consider these match rates to be acceptable, within the limitations of information available.

Representativeness of Linked MEDPAR

For analytical purposes, lack of representativeness is most important for characteristics that are related to outcomes we are trying to model. For example, if costs for treating a patient in free-standing facilities differed from costs in excluded units of acute care hospitals, we would consider re-weighting the sample of linked cases to adjust our total cost estimates.

Representativeness of Linked MEDPAR Hospital Characteristics

This section addresses the extent to which the facilities present in the UDSmr/COS file are representative of the set of all facilities that provide inpatient rehabilitation care to Medicare beneficiaries, and the extent to which UDSmr/COS patients are representative of all Medicare IRFPPS-eligible patients. This analysis reflects the effects of the partial-year sample available for some UDSmr/COS facilities as well as the sampling of MEDPAR facilities. The MEDPAR records contain data from over 1,000 IRFs in each year. Table J divides these facilities into free-standing rehabilitation facilities (free-standing rehab) and excluded rehabilitation units of acute-care hospitals (excluded units). It presents the number of facilities in the linked MEDPAR sample, along with the total MEDPAR counts of rehabilitation patients at these facilities.

TABLE J.—COMPARISON OF NUMBER OF UDSMR/COS AND MEDPAR REHABILITATION FACILITIES, BY TYPE

Type of facility	1996			1997		
	UDS/COS [1]	Total MEDPAR [2]	Percent UDS/COS	UDS/COS [1]	Total MEDPAR [2]	Percent UDS/COS
Number of rehab facilities:						
Free-standing rehab	130	204	64	142	212	67
Excluded unit	435	877	50	489	911	54
Total	565	1,081	42	631	1,123	56
Number of rehab patients:						
Free-standing rehab	86,301	114,933	75	94,327	118,541	80
Excluded unit	130,623	229,193	57	150,787	240,491	63
Total	216,924	344,126	63	245,114	359,032	68

[1] Hospitals with at least one linked MEDPAR/UDSmr/COS rehabilitation record.
[2] Total (matched and unmatched) rehabilitation cases.

As shown in Table J, UDSmr/COS slightly over-represents free-standing rehabilitation facilities and slightly under-represents excluded units. The table also indicates UDSmr/COS's tendency to include larger facilities. In 1997, UDSmr/COS facilities represented 47 percent of the facilities, but served almost 70 percent of all MEDPAR IRF cases. Based on data found in the table, in 1997, UDSmr/COS free-standing facilities had an average of 792 patients, 532 more than other-MEDPAR free-standing facilities, and UDSmr/COS excluded units had an average of 365 patients, 185 more than other-MEDPAR excluded units.

Table K shows the distribution of UDSmr/COS IRFs by size. This shows both that free-standing facilities are larger than excluded units, and that UDSmr/COS IRFs tend to be larger than other MEDPAR facilities within type of facility.

TABLE K.—COMPARISON OF SIZES OF UDSMR/COS AND MEDPAR FACILITIES, BY TYPE OF FACILITY

No. of MEDPAR patients	1996				1997			
	Free-standing		Excluded Unit		Free-standing		Excluded Unit	
	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR	UDS/COS	Other MEDPAR
1–100	2	23	30	97	4	24	33	105
101–200	14	9	139	140	14	7	143	126
201–300	14	2	105	102	11	5	123	103
301–400	14	10	59	48	17	9	65	40
401–500	8	8	38	27	12	7	52	29
501–1000	56	16	58	26	59	15	67	18
1001–2000	20	6	6	2	24	3	6	1
2001–3000	1	0	0	0	0	0	0	0
3001–4000	1	0	0	0	1	0	0	0
Total	130	74	435	442	142	70	489	422

Table L shows that there are some UDSmr/COS facilities in each region, although the southeast and mountain States appear to be slightly under represented.

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR UDSMR/COS SAMPLE HOSPITALS, BY STATE

State	1996			1997		
	Total		Percent UDS/COS	Total		Percent UDS/COS
	UDS/COS	MEDPAR		UDS/COS	MEDPAR	
AL	7,135	7,839	91	8,338	8,654	96
AK	136	247	55	153	302	51
AR	2,829	6,581	43	3,338	6,973	48
AZ	2,261	3,672	62	2,334	4,084	57
CA	8,108	15,294	53	7,899	15,559	51
CO	1,306	4,757	27	2,786	4,263	65
CT	1,521	2,217	69	2,024	2,290	88
DC	133	1,097	12	104	996	10
DE	1,061	1,399	76	985	1,361	72
FL	17,143	23,021	74	18,734	23,630	79
GA	6,115	9,615	64	7,014	10,716	65

TABLE L.—NUMBER AND PERCENTAGE OF MEDPAR REHABILITATION CASES FOR UDSMR/COS SAMPLE HOSPITALS, BY STATE—Continued

State	1996			1997		
	Total		Percent UDS/COS	Total		Percent UDS/COS
	UDS/COS	MEDPAR		UDS/COS	MEDPAR	
HI	1,087	1,087	100	1,016	1,016	100
IA	1,264	1,264	100	1,404	1,404	100
ID	1,781	1,829	97	1,773	1,807	98
IL	8,044	14,953	54	9,191	14,894	62
IN	5,330	8,943	60	5,349	8,884	60
KS	874	3,224	27	786	3,333	24
KY	3,859	5,198	74	4,083	5,201	79
LA	3,338	9,206	36	5,071	10,061	50
MA	4,532	8,765	52	5,748	8,631	67
MD	667	867	77	574	715	80
ME	130	1,255	10	1,047	1,460	72
MI	13,470	16,523	82	14,090	17,255	82
MN	1,115	2,048	54	1,554	2,112	74
MO	3,349	9,788	34	4,414	10,513	42
MS	1,701	1,968	86	1,747	2,021	86
MT	878	878	100	766	766	100
NC	6,325	7,123	89	7,752	8,771	88
ND	1,564	1,821	86	1,356	1,636	83
NE	1,094	1,195	92	1,008	1,107	91
NH	1,320	2,310	57	1,442	2,505	58
NJ	10,010	11,234	89	10,637	11,083	96
NM	364	1,283	28	452	1,277	35
NV	0	2,230	0	0	2,303	0
NY	7,905	21,431	37	11,618	22,875	51
OH	8,992	11,837	76	10,175	13,888	73
OK	3,238	6,356	51	4,100	6,949	59
OR	824	1,179	70	728	1,184	61
PA	23,437	36,989	63	24,806	35,700	69
RI	1,379	2,247	61	1,517	2,307	66
SC	3,758	4,536	83	4,200	4,878	86
SD	1,684	2,096	80	1,702	2,101	81
TN	7,574	10,731	71	8,477	11,917	71
TX	19,498	33,619	58	22,551	36,616	62
UT	369	858	43	610	984	62
VA	4,924	6,738	73	5,628	7,235	78
VT	446	603	74	412	567	73
WA	3,726	3,753	99	3,584	3,608	99
WI	5,741	6,591	87	6,201	6,690	93
WV	3,480	3,497	100	3,553	3,574	99
WY	105	334	31	283	376	75
Total	216,924	344,126	63	245,114	359,032	68

Representativeness of Patient and Stay Characteristics

Table M compares demographic characteristics of all Medicare rehabilitation patients with the matched UDSmr/COS sample. Of all the characteristics examined, the UDSmr/COS sample of discharges appears very similar.

TABLE M.—PATIENT CHARACTERISTICS FOR MEDPAR REHABILITATION INPATIENTS, BY UDSMR/COS STATUS

Patient characteristic	1996			1997		
	UDS/COS	Other MEDPAR	Total MEDPAR	UDS/COS	Other MEDPAR	Total MEDPAR
Sample Size	171,626	172,500	344,126	206,032	153,000	359,032
Average Age	75.4	75.6	75.5	75.4	75.6	75.5
Age 0–50	2.6%	2.8%	2.7%	2.8%	3.0%	2.8%
Age 51–60	3.1%	3.1%	3.1%	3.2%	3.2%	3.2%
Age 61–70	20.1%	19.3%	19.7%	19.5%	18.9%	19.2%
Age 71–80	44.2%	42.8%	43.5%	43.9%	42.8%	43.4%
Age 81–90	26.9%	28.1%	27.5%	27.4%	28.2%	27.7%
Age 91+	3.2%	3.9%	3.5%	3.2%	4.0%	3.6%
Male	37.9%	37.3%	37.6%	38.0%	37.6%	37.8%
White	86.7%	85.8%	86.3%	86.6%	85.3%	86.1%
Black	9.8%	10.6%	10.2%	10.1%	10.9%	10.4%
In-hospital death	0.2%	0.6%	0.4%	0.3%	0.7%	0.4%

Table N compares resources used for linked UDSmr/COS stays with those for other Medicare rehabilitation patients. Average length of stay for UDSmr/COS cases is the same as for non-UDSmr/COS patients. However, for cases in free-standing hospitals, UDSmr/COS stays consume fewer resources: LOS and total charges are about 10 percent less.

TABLE N.—COMPARISON OF RESOURCE USE FOR MEDICARE REHABILITATION INPATIENTS, BY UDSMR/COS STATUS

Hospitalization characteristic	1996			1997		
	UDS/COS	Other MEDPAR	Total MEDPAR	UDS/COS	Other MEDPAR	Total MEDPAR
All hospitals:						
Sample size	171,626	172,500	344,126	206,032	153,000	359,032
Length of Stay (days)	16.20	16.20	16.20	15.70	15.70	15.70
Daily therapy charges	$360.00	$351.00	$355.00	$379.00	$368.00	$374.00
Total therapy charges	$5,960.00	$5,829.00	$5,894.00	$6,064.00	$5,924.00	$6,004.00
Total charges	$18,013.00	$18,790.00	$18,403.00	$18,348.00	$19,287.00	$18,748.00
Freestanding hospitals:						
Sample size	65,349	49,584	114,933	82,393	36,148	118,541
Length of Stay (days)	18.0	18.9	18.4	17.8	19.2	18.2
Daily therapy charges	$360.00	$387.00	$371.00	$384.00	$406.00	$391.00
Total therapy charges	$6,652.00	$7,605.00	$7,063.00	$7,002.00	$8,064.00	$7,325.00
Total charges	$19,443.00	$21,214.00	$20,207.00	$20,202.00	$22,541.00	$20,915.00

Note: UDSmr/COS case totals count matched cases, hence differ from Table J which counts matched and unmatched cases.

Appendix B: Variables Suggested for Exclusion from the MDS–PAC Instrument

During the pilot and field testings of versions 7–9 of the MDS–PAC, a number of assessors (Registered Nurses, Physical Therapists, or Occupational Therapists) were asked to rate which items on the MDS–PAC they would suggest dropping. Based on these findings, the MDS–PAC no longer includes 104 items that were originally field tested in Version 8 of the instrument. The table below describes the percentage of assessors by facility type (rehabilitation hospital or skilled nursing facility) who recommended dropping each of the MDS–PAC items displayed in the table. The table is broken down by the type of facility in which the assessor was employed. The items in the table below are the majority of the items that are now in the version of the MDS–PAC found in Appendix BB.

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
A1A	First Name	0	8.3
A1B	Middle Initial	0	8.3
A1C	Last Name	0	8.3
A1D	Jr/Sr	0	8.3
A3	Reason for Assessment	5.9	2.0
A5A	Medical Stabilization	5.8	10.0
A5B	Rehab/Functional Improvement	4.7	4.0
A5C	Recuperation	12.8	18.0
A5D	Monitor to Avoid Clinical Complication	9.2	6.0
A5E	Palliative Care	18.6	6.0
A6	Admitted from	6.5	4.8
A7A	Time of Onset of Precipitating Event	15.4	33.3
A7B	Reason Most Recent Acute Care Hospitalization	8.6	10.0
A8A	Primary Payment Source for Stay	2.3	4.0
A8B	Secondary Payment Source for Stay	5.7	8.2
A9	Marital Status	4.7	4.2
AA10	Gender	0	2.0
AA11	Birthdate	0	8.3
AA12A	American Indian/Alaskan Native	12.0	16.7
AA12B	Asian	12.0	16.7
AA12C	Black or African-American	12.0	16.7
AA12D	Native Hawaiian or Other Pacific Islander	12.0	16.7
AA12E	White	12.0	16.7
AA12F	Hispanic or Latino	15.4	16.7
AA13	Date of Reentry	12.9	14.3
A10	Education	10.3	6.0
A11A	Primary Language	1.2	2.0
A11B	Other Language	2.4	2.0
A12	Dominant Hand	9.2	50.0
A13	Mental Health History	12.3	4.9
A14	Conditions Related to MR/DD Status	12.5	25.0
A15A	Legal Guardian	7.5	5.0
A15B	Other Legal Oversight	7.5	5.0
A15C	Durable Power of Attorney/Health	7.5	5.0
A15D	Patient Responsible for Self	7.5	5.0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
A16A	Living Will	11.5	2.0
A16B	Do Not Resuscitate	13.8	0
A16C	Do Not Hospitalize	16.1	4.1
A16D	Other Treatment Restrictions	13.8	2.0
A16E	None of the above	12.6	2.0
AA2A	Date of Entry	3.1	0
AA4	Assessment Reference Date	0	0
AA6A	Social Security #	3.4	0
AA6B	Medicare #	0	0
AA7	Medical Record &num	2.3	0
AA8A	State #	6.9	2.0
AA8B	Federal #	4.7	0
AA9	Medicaid #	1.2	0
B1	Comatose	14.8	0
B2A	Short-term Memory Ok	0	2.0
B2B	Long-term Memory Ok	0	2.0
B2C	Situational Memory Ok	8.2	0
B2D	Procedural Memory Ok	5.9	0
B3A	Decisions Regarding Tasks of Daily Life	2.3	0
B3B	Status Compared to 30 Days Ago	6.9	24.5
B4A	Easily Distracted	5.7	0
B4B	Periods of Altered Perception	5.7	2.0
B4C	Episodes of Disorganized Speech	5.7	4.1
B4D	Periods of Restlessness	5.7	2.0
B4E	Periods of Lethargy	6.1	0
B4F	Mental Function Varies over Course of Day	7.4	0
C1	Hearing	3.4	0
C2A	Hearing Aid	4.5	0
C2B	Lip Reading	4.9	0
C2C	Signs/Gestures/Jokes	5.7	0
C2D	Message to Express Needs	4.5	0
C2E	None of the Above	4.5	0
C3A	Expressing Information Content	1.1	22.4
C3B	Status Compared to 30 Days Ago	8.0	2.0
C2	Speech Clarity	0	0
C5A	Verbal Content	0	0
C5B	Status Compared to 30 Days Ago	7.0	22.4
C6A	See in Adequate Light W/Glasses	1.2	0
C6B	More Impaired in Vision	7.4	22.5
D1A	Patient Made Negative Statements	3.8	0
D1B	Persistent Anger W/Self or Others	3.8	0
D1C	Expressions of Unrealistic Fears	11.5	0
D1D	Repetitive Anxious Complaints	7.7	0
D1E	Repetitive Health Complaints	11.5	0
D1F	Sad, Pained, Facial Expressions	7.7	0
D1G	Crying, Tearfulness	3.8	0
D1H	Repetitive Physical Movements	11.5	0
D1IS	Insomnia/change in Sleep Patterns	3.8	0
D1J	W/draw from Activities of Interest	11.5	0
D1K	Reduced Social Interaction	7.7	0
D2	Mood Persistence	4.8	5.0
D3A	Wandering—Freq	3.4	0
D3B	Verbal Abuse Behavior—Freq	4.6	0
D3C	Physical Abuse Behavior—Freq	3.4	2.1
D3D	Social Inappropriate Behavior—Freq	3.4	2.1
D3E	Resists Care—Freq	3.4	0
E10AA	Leg—Joint	4.7	4.2
E10AB	Voluntary Motor Control Leg	5.1	2.6
E10AC	Intact Touch Leg	7.6	10.3
E10BA	Arm-Joint	4.7	4.2
E10BB	Voluntary Motor Control Arm	5.1	2.6
E10BC	Intact Touch Arm	7.6	10.3
E10CA	Trunk & Neck—Joint	7.0	4.2
E10CB	Vol. Motor Control—Trunk & Arm	7.6	2.6
E10CC	Intact Touch Trunk & Arm	8.9	10.3
E1A	Bed Mobility—3 Days	2.4	0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
E1B	Transfer Bed/Chair—3 Days	2.4	2.0
E1C	Locomotion—3 Days	2.4	2.0
E1D	Walk in Corridor—3 Days	4.7	4.1
E1E	Dressing Upper Body—3 Days	2.4	0
E1F	Dressing Lower Body—3 Days	2.4	0
E1G	Eating—3 Days	2.4	0
E1H	Toilet Use—3 Days	2.4	0
E1I	Transfer Toilet—3 Days	2.3	4.1
E1J	Personal Hygiene—3 Days	2.3	0
E1K	Bathing—3 Days	2.4	0
E1L	Transfer Tub/shower—3 Days	4.7	4.1
E3	ADL Areas Now More Impaired	4.0	16.7
E4A	Meal Preparation—Now	4.5	23.4
E4C	Phone Use—Now	10.2	25.5
E4D	Medication Management—Now	4.5	31.9
E4E	Stairs—Now	4.5	23.4
E4F	Car Transfer—Now	5.7	23.4
E5	IADL Areas Now More Impaired	3.8	16.7
E6A	Cane/Crutch	0	0
E6B	Walker	2.3	0
E6C	Wheeled—Not Motorized	2.5	0
E6D	Adaptive Eating Utensil	0	9.1
E6E	Mechanical Lift	3.4	2.2
E6F	Orthotics/Prosthesis	0	18.2
E6G	Postural Support	3.4	2.2
E6H	Slide Board	3.4	2.2
E6I	Other Adaptive Device	2.3	2.2
E6J	None of Above	2.5	2.7
E7A	Hours of Physical Activity—past 24 Hrs	6.5	45.0
E7B	Hours of Physical Activity—30 Days Ago	29.4	50.0
E8A	Distance Walk W/o Sit Down—Consistently	4.6	6.3
E8B	Walking Support Provided	11.1	25.6
E9A	Moved from Seated to Standing	8.0	2.1
E9B	Turned Around Face Opposite Direction	14.8	8.3
F1A	Control of Urinary Bladder	0	0
F1B	Continence Compared to 30 Days Ago	4.5	22.4
F2A	External Catheter	1.1	0
F2B	Indwelling Catheter	2.3	4.1
F2C	Intermittent Cath	2.5	0
F2F	Pads, Briefs	3.7	0
F4	Bowel Continence	1.1	2.0
F5	Bowel Appliances	2.5	0
G2A	Diabetes Mellitus	0	8.3
G2AA	A Multiple Sclerosis	0	8.3
G2AB	Parkinson's Disease	0	8.3
G2AC	Quadriplegia	0	8.3
G2AD	Seizure Disorder	0	8.3
G2AE	Spinal Cord Dysfunction—Nontraumatic	0	8.3
G2AF	Spinal Cord Dysfunction—Traumatic	0	8.3
G2AG	Stroke	0	8.3
G2AH	Anxiety Disorder	0	8.3
G2AI	Depression	0	8.3
G2AJ	Other Psychiatric Disorder	0	8.3
G2AK	Asthma	0	8.3
G2AL	COPD	0	8.3
G2AM	Emphysema	0	8.3
G2AN	Cancer	4.2	8.3
G2AO	Post Surgery—Non Orthopedic	4.2	8.3
G2AP	Renal Failure	0	8.3
G2AQ	None of Above	0	8.3
G2B	Hypothyroidism	0	8.3
G2C	Cardiac Arrhythmias	0	8.3
G2D	Congestive Heart Failure	0	8.3
G2E	Coronary Artery Disease	0	8.3
G2F	Deep Vein Thrombosis	0	8.3
G2G	Hypertension	0	8.3

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
G2H	Hypotension	0	8.3
G2I	Peripheral Vascular Disease	0	8.3
G2J	Post Acute MI	0	8.3
G2K	Post Heart Surgery	0	8.3
G2L	Pulmonary Embolism	0	8.3
G2M	Pulmonary Failure	0	8.3
G2N	Other Cardiovascular Disease	0	8.3
G2O	Fracture—Hip	0	8.3
G2P	Fracture—Lower Extremity	0	8.3
G2Q	Fracture(s)—Other	0	8.3
G2R	Osteoarthritis	0	8.3
G2S	Osteoporosis	0	8.3
G2T	Rheumatoid Arthritis	0	8.3
G2U	Alzheimer's Disease	0	8.3
G2V	Aphasia or Apraxia	0	8.3
G2W	Cerebral Palsy	0	8.3
G2X	Dementia Other than Alzheimer's	0	8.3
G2Y	Hemiplegia/Hemiparesis	0	8.3
G3A	Antibiotic Resistant Infection	0	2.0
G3B	Cellulitis	0	2.5
G3C	Hepatitis	1.2	2.0
G3D	HIV/AIDS	1.2	2.0
G3E	Pneumonia	0	2.0
G3F	Osteomyelitis	0	2.0
G3G	Septicemia	1.2	2.0
G3H	Staphylococcus Infection	1.2	4.1
G3I	Tuberculosis (Active)	1.2	2.0
G3J	Urinary Tract Infection	0	2.0
G3K	Wound Infection	0	2.0
G3L	None of Above	0	2.0
G4AA	ICD–9–CM Diagnosis Code #1	10.8	4.2
G4AB	ICD–9–CM Code #1	8.4	4.2
G4BA	ICD–9–CM Diagnosis Code #2	10.8	4.2
G4BB	ICD–9–CM Code #2	8.4	4.2
G4CA	ICD–9–CM Diagnosis Code #3	11.0	4.2
G4CB	ICD–9–CM Code #3	8.5	4.2
G4DA	ICD–9–CM Diagnosis Code #4	11.0	4.2
G4DB	ICD–9–CM Code #4	8.5	4.2
G4EA	ICD–9–CM Diagnosis Code #5	12.2	4.2
G4EB	ICD–9–CM Code #5	9.8	4.2
H1	Vital Signs	4.6	12.5
H2A	Dizziness/Vertigo/Lightheaded	1.1	0
H2B	Fell in past 7 Days	1.1	4.1
H2C	Fell in past 8 to 180 Days	7.7	0
H3D	Advanced Cardiac Failure	9.1	10.2
H2E	Chest Pain/Pressure on Exertion	1.1	2.0
H2F	Chest Pain/Pressure at Rest	1.1	2.0
H2G	Edema—Generalized	1.1	2.0
H2H	Edema—Localized	2.3	2.0
H2I	Edema—pitting	3.4	2.1
H2J	Impaired Aerobic Capacity	3.4	2.0
H2K	Constipation	1.1	0
H2L	Dehydrated	3.4	0
H2M	Diarrhea	1.1	0
H2N	Internal Bleeding	3.8	0
H2O	Recurrent Nausea/Vomiting	2.3	0
H2P	Refuse/Inability to Take Liquids Orally	6.8	0
H2R	Fever	4.5	0
H2S	Hemi-neglect	4.5	0
H2T	Cachexia (Severe Malnutrition)	6.8	0
H2U	Morbid Obesity	3.4	0
H2V	End-stage Disease	4.5	0
H2W	None of Above	0	0
H3A	Inability to Lie Flat—Loss of Breath	2.3	0
H3B	Shortness of Breath—Exertion	3.4	0
H3C	Shortness of Breath—Rest	3.4	0

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
H3D	Oxygen Saturation	3.4	2.0
H3E	Diff Cough/clearing Airway	3.4	0
H3F	Recurrent Aspiration	2.3	0
H3G	Recurrent Aspiration Infection	4.9	0
H3H	None of Above	3.5	0
H4A	Highest Pressure Ulcer Stage	2.3	0
H4B	# of Current Pressure Ulcers	2.4	0
H4C	Length Multiplied by Width	4.7	12.2
H4D	Exudate Amount	4.7	12.2
H4E	Predominant Tissue	4.7	12.2
H4F	Total Push Score	4.7	10.4
H5A	# of Stasis Ulcers	3.4	0
H5B	# of Surgical Wounds	3.4	0
H5C	Ulcer Resolved/Healed	8.4	6.1
H6A	Burns	2.3	2.0
H6B	Open Lesions Excluding Foot	2.3	0
H6C	Rashes	1.1	0
H6D	Skin Tears or Cuts	1.1	0
H6E	None of Above	1.1	0
I1A	Freq Patient Complains of Pain	0	0
I1B	Intensity of Pain	0	0
I1C	Current Pain Status	7.3	26.8
J1A	Chewing Problem	1.2	0
J1B	Dental Problems	1.2	0
J2	Swallowing	1.2	0
J3A	Height in Inches	5.8	0
J3B	Weight in Pounds	7.0	0
J4A	Weight Loss	8.1	4.2
J4B	Weight Gain	8.2	4.2
J5A	Total Calories	3.5	0
J5B	Fluid Intake	4.6	0
K1A	Total # Physician Visits	21.6	22.4
K1B	# Times Phys/nurse Practitioner Called to Bedside	17.2	40.0
K1C	# Nurse Practitioner Visits	20.7	27.1
K1D	# Phys Asst Visits	20.7	29.2
K1E	# New or Changed Orders	14.9	22.4
K2AA	Diabetic Management	3.5	8.3
K2AB	At Dis—insulin Management	7.7	33.3
K2BA	Injections	7.7	8.3
K2BB	Injections at Discharge	8.3	20.0
K2CA	IV Antibiotics/meds	7.7	8.3
K2CB	At Dis—Iv Antibiotics/meds	7.7	33.3
K2DA	Application of Dressings	7.7	8.3
K2DB	Application of Dressings at Dis.	8.3	20.0
K2EA	Application of Ointments	7.7	8.3
K2EB	At Dis—Application of Ointments	7.7	33.3
K2GA	Nutrition/dehydration Intervention	7.7	8.3
K2GB	At Dis—nutrition/hydration Intervention	7.7	33.3
K2HA	Pressure Relieving Bed/Chair	3.8	8.3
K2HB	At Dis—Pressure Relieving Bed/Chair	7.7	33.3
K2IA	Turning and Repositioning	3.8	8.3
K2IB	At Dis—Turning and Repositioning	7.7	33.3
K2JA	Ulcer Care	7.7	8.3
K2JB	At Discharge—Ulcer Care	7.7	33.3
K2KA	Wound Care—Surgical	7.7	8.3
K2KB	At Dis—Wound Care Surgical	7.7	33.3
K2LA	Bladder Training	3.8	8.3
K2LB	At Dis—Bladder Training	8.3	20.0
K2MA	Scheduled Toileting	3.8	8.3
K2MB	At Dis—Scheduled Toileting	8.3	20.0
K2NA	Bowel Program	3.8	8.3
K2NB	At Dis—Bowel Program	8.3	20.0
K2OA	Cardiac Monitoring/Rehab	11.5	8.3
K2OB	At Dis—Cardiac Monitoring	7.7	33.3
K2PA	Cast(s)	11.5	8.3
K2PB	At Dis—Cast(s)	7.7	33.3

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
K2QA	Continuous Positive Airway Pressure	11.5	8.3
K2QB	At Dis—Continuous Positive Airway Pressure	9.0	33.3
K2RA	Drains	3.8	0
K2RB	At Dis—Drains	7.7	31.7
K2SA	Dialysis	0	0
K2SB	At Dis—Dialysis	4.2	16.7
K2TA	Enteral Tube Feeding	0	0
K2TB	At Dis—Enteral Tube Feeding	6.5	31.7
K2UA	IV Line—Central	3.8	0
K2UB	At Dis—Central Iv Line	7.7	31.7
K2VA	IV Line—Peripheral	3.8	0
K2VB	At Dis—Peripheral Iv Line	7.7	31.7
K2WA	Ng Feeding Tube	0	0
K2WB	At Dis—NG Feeding Tube	6.4	31.7
K2XA	Oxygen	0	0
K2XB	At Dis—Oxygen	6.4	31.7
K2YA	Pain Management—Other than Drugs	7.7	0
K2YB	At Dis—Pain Management	7.7	31.7
K2ZA	Suctioning—Oral	0	0
K2ZB	At Dis—Suctioning—Oral	7.7	31.7
K2AAA	Suctioning—Tracheal	0	0
K2AAB	At Dis—Suctioning Tracheal	7.7	31.7
K2ABA	Tracheostomy Care	0	0
K2ABB	At Dis—Tracheostomy Care	6.4	31.7
K2ACA	Transfusion(s)	7.7	0
K2ACB	At Dis—Transfusion(s)	7.7	31.7
K2ADA	Ventilator or Respirator	7.7	0
K2ADB	At Dis—Vent. Or Resp.	9.0	31.7
K2AEA	Ventilator Weaning	7.7	0
K2AEB	At Dis—Ventilator Weaning	9.0	31.7
K2AFA	Train Family to Assist Patient	3.8	0
K2AFB	At Dis-Train Family to Assist Patient	6.4	31.7
K2AGA	Training in Health Maint	3.8	0
K2AGB	At Dis—Pat Train Skills Required after Discharge	6.4	31.7
K2AHA	Design and Implementation	3.8	0
K2AHB	At Dis—Social Service Design	7.7	31.7
K3AIA	None of Above	0	0
K3AIB	At Dis—None of Above	7.7	31.7
K3A	Range of Motion—Passive	4.5	8.2
K3B	Range of Motion—Active	4.5	8.2
K3C	Splint/Orthotic Assistance	4.5	8.2
K3D	Bed Mobility	4.5	8.2
K3E	Bladder/Bowel	3.4	8.2
K3F	Transfer	4.5	8.2
K3G	Walking	4.5	8.2
K3H	Dressing or Grooming	3.4	8.2
K3I	Eating or Swallowing	3.4	8.2
K3K	Communication	3.4	8.2
K4AA	Speech—Days Ordered	16.0	26.2
K4AB	Speech—Days Delivered	2.4	4.8
K4AC	Speech—Min Delivered	3.7	2.4
K4AD	Post Dis—Speech	4.0	18.0
K4BA	Ot—Days Ordered	17.3	26.2
K4BB	Ot—Days Delivered	2.4	4.8
K4BC	Ot—Min Delivered	2.5	2.4
K4BD	Post Dis—Ot	5.3	18.2
K4CA	Pt—Days Ordered	17.3	26.2
K4CB	Pt—Days Delivered	1.2	4.8
K4CC	Pt—Min Delivered	3.7	2.4
K4CD	Pt—Post Dis—Pt	5.3	18.2
K4DA	Resp. Therapy—Days Ordered	16.0	26.2
K4DB	Resp. Therapy—Days Delievered	2.4	4.8
K4DC	Resp. Therapy—Min. Delivered	3.7	2.4
K4DD	Post Dis—Resp.Therapy	4.0	18.2
K4EA	Psych Therapy—Days Ordered	18.5	26.2
K4EB	Psych Therapy—Days Delivered	3.7	4.8

TABLE 1.—PERCENT OF ASSESSORS BY THE TYPE OF FACILITY WHO RECOMMENDED REMOVAL OF MDS–PAC ITEMS—Continued

MDS–PAC item No.	MDS–PAC item	Percent of assessors by facility-type who recommended removal of specific MDS–PAC items	
		Rehabilitation hospitals	Skilled nursing facilities
K4EC	Psych Therapy—Min Delivered	3.7	2.4
K4ED	Post Dis—Psych Therapy	6.7	18.2
K4FA	Therapeutic Recreation—Days Ordered	18.7	24.2
K3FB	Therapeutic Recreation—Days Delivered	1.3	3.0
K3FC	Therapeutic Recreation—Min Delivered	5.3	0
K3FD	Post Dis—Therapeutic Recreation	6.7	18.2
K5A	Full Bed Rails on Both Sides	5.1	0
K5B	Other Types of Side Rails Used	6.4	4.9
K5C	Trunk Restraint	6.4	0
K5D	Chair Prevents Rising	7.7	2.4
L1A	Bed Mobility/Transfer	6.9	10.2
L1B	Dressing	6.9	10.2
L1C	Eating	6.9	10.2
L1D	Locomotion	6.9	10.2
L1F	Medication Managment	6.8	14.3
L1G	Pain Management	6.8	10.2
L2A	Believe Is Capable of Incr Indep.	5.7	10.4
L2B	Unable to Recognize New Limits	8.0	10.4
L2C	Fails to Initiate/Continue Adls	9.2	10.4
L3A	Functional Status—Last 3 Days	9.2	12.2
L3B	Health Status—Last 3 Days	9.3	12.2
L4	Estimated Length of Stay	2.3	6.0
M1A	Emotional Support	0	8.3
M1B	Intermit Phys Support—less than Daily	0	8.3
M1C	Intermit Phys Support—Daily	0	8.3
M1D	Full Time Physical Support	0	8.3
M1E	All or Most of Nec Transportation	0	9.1
M2A	Family Overwhelmed by Pat. Illness	4.2	16.7
M2B	Family Relationship Require Great Deal of Staff Time	4.2	8.3
M3AA	Type of Residence—Pre	2.3	10.2
M3AB	Type of Residence—Discharge	0	10.0
M3AC	Temp. Type of Residence	5.0	12.5
M3BA	Lived With—Pre	2.5	10.6
M3BB	Live With—Disch	0	10.4
M3BC	Temp Live(d) With	5.3	13.2
N1C	Date Assessment Coord Signed	0	0

BILLING CODE 4120–03–P

APPENDIX BB Patient_____Numeric Identifier_____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
INTERRUPTED STAY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	**LEGAL NAME OF PATIENT**	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	**ADMISSION DATE**	a. *Date the stay began (date of initial admission)* Month Day Year b. *Date Medicare covered Part A stay began — If different than* ***AA2a*** Month Day Year
6.	**SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]**	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
7.	**MEDICAL RECORD NO.**	
8.	**FACILITY PROVIDER NO.**	a. State No. b. Federal No.
9.	**MEDICAID NO.**	***["+" if pending, "N" if not a Medicaid recipient]***
10.	**GENDER**	1. Male 2. Female
11.	**BIRTHDATE**	Month Day Year
12.	**ETHNICITY/ RACE**	(***CHECK all that apply***) ***ETHNICITY*** Hispanic or Latino ***RACE*** American Indian/Alaskan Native a. Asian b. Black or African American c. Native Hawaiian or other Pacific Islander d. White
13.	**INTERRUPTED STAY**	a. *Date/time departed from the rehabilitation unit/hospital* Month Day Year Hours Minutes AM/PM b. *Date/time returned to the rehabilitation unit/hospital* Month Day Year Hours Minutes AM/PM
14.	**CLINICIAN COMPLETING ASSESSMENT**	a. **SIGNATURE OF CLINICIAN ATTESTING TO THE ACCURACY OF THE DATES THE PATIENT DEPARTED FROM AND RETURNED TO THE REHABILITATION UNIT/HOSPITAL** Printed Name b. (First) c. (Middle Initial) d. (Last) e. (Suffix) f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist

APPENDIX BB Patient_____Numeric Identifier_____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*

• Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	LEGAL NAME OF PATIENT	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	ADMISSION DATE	a. *Date the stay began (date of initial admission)* Month — Day — Year b. *Date Medicare covered Part A stay began — If different than **AA2a*** Month — Day — Year
3.	REASON FOR ASSESSMENT	1. Admission (covers first 3 days, completed on day 4) 2. Reassessment completed on day 11 3. Reassessment completed on day 30 4. Reassessment completed on day 60 5. Discharge assessment completed day 5 after discharge
4.	ASSESSMENT REFERENCE DATE	*Assessment reference date—last day of the 3-day MDS-PAC observation period* Month — Day — Year
5.	DISCHARGE STATUS	a. *Last day of stay* Month — Day — Year b. *If discharged, status at discharge* 0. Rehabilitation program complete for this stay and return not anticipated 1. Patient left, against medical advice, prior to completion of plan of care 2. Acute problem, discharge to acute hospital 3. Patient died
6.	SOCIAL SECURITY AND MEDICARE NUMBERS [C in 1st box if non Med. no.]	a. Social Security Number — — b. Medicare number (or comparable railroad insurance number)
7.	MEDICAL RECORD NO.	
8.	FACILITY PROVIDER NO.	a. State No. b. Federal No.
9.	MEDICAID NO.	*["+" if pending, "N" if not a Medicaid recipient]*
10.	GENDER	1. Male 2. Female
11.	BIRTHDATE	Month — Day — Year
12.	ETHNICITY/ RACE	(*CHECK all that apply*) ***ETHNICITY*** Hispanic or Latino (a.) ***RACE*** American Indian/Alaskan Native (b.) Asian (c.) Black or African American (d.) Native Hawaiian or other Pacific Islander (e.) White (f.)

SECTION AB. ASSESSMENT ATTESTATION

1.	PERSON COMPLETING ASSESSMENT	a. SIGNATURE OF CLINICIAN ATTESTING TO COMPLETION OF ASSESSMENT: Printed Name b. (First) c. (Middle Initial) d. (Last) e. (Suffix) f. Credentials: 1. Physician 2. Registered nurse 3. Physical therapist 4. Occupational therapist g. Date MDS-PAC signed as complete Month — Day — Year

2a. Signatures of staff completing part of the assessment	Credentials	Sections	Date
b.			Date
c.			Date
d.			Date
e.			Date
f.			Date

APPENDIX BB Patient _____ Numeric Identifier _____

MINIMUM DATA SET — POST ACUTE CARE (MDS-PAC) — *Version 1.0*
FULL ASSESSMENT FORM (ASSESSMENT, REASSESSMENT, DISCHARGE)

SECTION A. DEMOGRAPHIC/ADMISSION INFORMATION HISTORY

- **Assessment reflects activities *OVER LAST 3 DAYS* unless otherwise indicated**

1.	LEGAL NAME OF PATIENT	a. (First) b. (Middle Initial) c. (Last) d. (Suffix)
2.	ADMISSION DATE	a. *Date the stay began (date of initial admission)* Month — Day — Year b. *Date Medicare covered Part A stay began — If different than* ***A2a*** Month — Day — Year
3.	REASON FOR ASSESSMENT	1. Admission (covers first 3 days, completed on day 4) 2. Reassessment completed on day 11 3. Reassessment completed on day 30 4. Reassessment completed on day 60 5. Discharge assessment completed day 5 after discharge
4.	ADMISSION STATUS	0. First admission to inpatient rehabilitation services 1. Readmission to rehabilitation but not directly from other rehabilitation 2. Readmission directly from other rehabilitation
5.	GOALS FOR STAY	***CODE indicate all that apply:*** 0. No 1. Yes a. Medical stabilization b. Rehabilitation/Functional improvement c. Recuperation d. Monitoring to avoid clinical complication e. Palliative care
6.	ADMITTED FROM (At date of admission—A2)	1. Private home 2. Private apartment 3. Rented room 4. Board and care/group home 5. Assisted living 6. Homeless shelter 7. Transitional living 8. Long term care facility (nursing home) 9. Post acute care SNF 10. Acute care hospital—not rehabilitation unit 11. Rehabilitation unit (in acute hospital) 12. Rehabilitation hospital 13. Long term care hospital 14. Psychiatric hospital/unit 15. MR/DD facility (exclude group home) 16. Other hospital 17. Outpatient surgery center 18. Other
7.	PRECIPITATING EVENT PRIOR TO ADMISSION	a. ***Time of the onset of the precipitating event/problem*** *that directly preceded admission into this facility (time from date of admission—**item A2**)* 0. Within last week 1. Within last 8 to 14 days 2. 15 to 30 days ago 3. 31 to 60 days ago 4. More than 60 days ago b. *Date of admission of most recent acute hospitalization (**within last 90 days**)* Month — Day — Year c. *Reason for most recent acute care hospitalization (**within last 90 days**)* 0. Not hospitalized at any time in **last 90 days** 1. New problem 2. Exacerbation 3. Both
8.	PRIMARY AND SECONDARY PAYMENT SOURCE FOR STAY	0. None - No insurance coverage, no private pay 1. Medicare 2. Medicaid 3. CHAMPUS 4. Department of Veterans Affairs 5. Managed care/HMO—Medicare 6. Managed care/HMO—non-Medicare 7. Private insurance 8. Private pay—self or family 9. Workers' compensation 10. Other payment A Prim B Sec
9.	MARITAL STATUS	1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced
10.	EDUCATION (*Highest Level Completed*)	1. No schooling 2. 8th grade/less 3. 9th-11th grade 4. High school 5. Technical or trade school 6. Some college 7. Bachelor's degree 8. Graduate degree
11.	LANGUAGE	a. *Primary Language* 0. English 1. Spanish 2. French 3. Other, specify in **A11b** b. ***If other, specify***
12.	DOMINANT HAND	1. Right 2. Left 3. Unable to determine
13.	MENTAL HEALTH HISTORY	*Patient's RECORD indicates history of mental retardation, mental illness, or developmental disability problem* 0. No 1. Yes
14.	CONDITIONS RELATED TO MR/DD STATUS	1. Not applicable—no MR/DD 2. MR/DD with no organic condition 3. MR/DD with organic condition
15.	RESPONSIBILITY/ LEGAL GUARDIAN	(***CHECK all that apply***) Legal guardian [a.] Other legal oversight [b.] Durable power of attorney/health care proxy [c.] Patient responsible for self [d.] *NONE OF ABOVE* [e.]
16.	ADVANCE DIRECTIVES	(***CHECK all that apply*** *that have supporting* ***documentation***) Living will [a.] Do not resuscitate [b.] Do not hospitalize [c.] Treatment restrictions [d.] *NONE OF ABOVE* [e.]

SECTION B. COGNITIVE PATTERNS

1.	COMATOSE	*Persistent vegetative state/no discernible consciousness* 0. No 1. Yes (**IF YES, SKIP TO SECTION E**)
2.	MEMORY/ RECALL ABILITY (Over last 3 days)	(***CODE for recall of what was learned or known***) 0. Memory OK 1. Memory problem a. Short-term memory OK—Seems/appears to recall after 5 minutes b. Long-term memory OK—Seems/appears to recall long past c. Situational memory OK—**Both**: recognizes staff names/faces frequently encountered **AND** knows location of places regularly visited (bedroom, dining room, activity room, therapy room) d. Procedural memory OK—Can perform all or almost all steps in a multitask sequence without cues for initiation
3.	COGNITIVE SKILLS FOR DAILY DECISION MAKING (Over last 3 days)	a. *Making decisions regarding tasks of daily life* 0. *INDEPENDENT*—Decisions consistent/reasonable/safe 1. *MODIFIED INDEPENDENCE*—Some difficulty in new situations only 2. *MINIMALLY IMPAIRED—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times* 3. *MODERATELY IMPAIRED*—Decisions consistently poor or unsafe, cues/supervision required at all times 4. *SEVERELY IMPAIRED*—Never/rarely made decisions b. ***Is now more impaired*** *in decision making than prior to precipitating event (item **A7a**)* 0. No or unsure 1. Yes, more impaired today
4.	INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (Over last 7 days)	(***CODE for behavior in the last 7 days.***) [***Note: Accurate assessment requires conversations with staff and family who have direct knowledge of patient's behavior over this time***]. 0. Behavior not present 1. Behavior present, not of recent onset 2. Behavior present, over last 7 days appears different from patient's usual functioning (e.g., new onset or worsening) a. **EASILY DISTRACTED**—(e.g., difficulty paying attention; gets sidetracked) b. **PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS**—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day) c. **EPISODES OF DISORGANIZED SPEECH**—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought) d. **PERIODS OF RESTLESSNESS**—(e.g., fidgeting or picking at skin, clothing, napkins, etc.; frequent position changes; repetitive physical movements or calling out) e. **PERIODS OF LETHARGY**—(e.g., sluggishness; staring into space; difficult to arouse; little body movement) f. **MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY**—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

SECTION C. COMMUNICATION/VISION PATTERNS (Over last 3 days)

1.	HEARING	*With hearing appliance, if used* 0. *HEARS ADEQUATELY*—No difficulty in normal conversation, social interaction, TV, phone 1. *MINIMAL DIFFICULTY*—Requires quiet setting to hear well 2. *HEARS IN SPECIAL SITUATIONS ONLY*—Speaker has to increase volume and speak distinctly 3. *HIGHLY IMPAIRED*—Absence of useful hearing
2.	MODES OF COMMUNICATION	(***CHECK all used by patient to make needs known***) Hearing aid [a.] Lip reading [b.] Signs/gestures/sounds [c.] Writing messages to express or clarify needs [d.] *NONE OF ABOVE* [e.]
3.	MAKING SELF UNDERSTOOD (Expression)	a. *Expressing information content—however able* 0. *UNDERSTOOD*—Expresses ideas without difficulty 1. *USUALLY UNDERSTOOD*—Difficulty finding words or finishing thoughts *BUT* if given time, little or no prompting required 2. *OFTEN UNDERSTOOD*—Difficulty finding words or finishing thoughts, prompting usually required 3. *SOMETIMES UNDERSTOOD*—Ability is limited to concrete requests 4. *RARELY/NEVER UNDERSTOOD* b. ***Is now more impaired*** *in making self understood by others than was prior to precipitating event (item **A7a**)* 0. No or unsure 1. Yes, more impaired today

APPENDIX BB Patient_____ Numeric Identifier_____

4.	SPEECH CLARITY	0. *CLEAR SPEECH*—Distinct, intelligible words 1. *UNCLEAR SPEECH*—Slurred, mumbled words 2. *NO SPEECH*—Absence of spoken words	
5.	ABILITY TO UNDERSTAND OTHERS (Comprehension)	**a.** *Understanding verbal information content (however able) with hearing appliance, if used* 0. *UNDERSTANDS*—Clear comprehension 1. *USUALLY UNDERSTANDS*—Misses some part/intent of message *BUT* comprehends most conversation with little or no prompting 2. *OFTEN UNDERSTANDS*—Misses some part/intent of message, with prompting can often comprehend conversation 3. *SOMETIMES UNDERSTANDS*—Responds adequately to simple, direct communication only 4. *RARELY/NEVER UNDERSTANDS* **b.** *Is* ***now more impaired*** *in understanding others than was prior to precipitating event (item* ***A7a****)* 0. No or unsure 1. Yes, more impaired today	
6.	VISION	**a.** *Ability to see in adequate light and with glasses, if used* 0. *ADEQUATE*—Sees fine detail, including regular print, in newspaper/books 1. *IMPAIRED*—Sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—Limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—Object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—No vision, eyes do not appear to follow objects BUT may report seeing light or colors only **b.** *Is* ***now more impaired*** *in vision than was prior to precipitating event (item* ***A7a****)* 0. No or unsure 1. Yes, more impaired today	

SECTION D. MOOD AND BEHAVIOR PATTERN

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD (Over last 3 days)	(***CODE for indicators observed in last 3 days, irrespective of the assumed cause***) 0. Indicator not exhibited in last 3 days 2. Exhibited on each of last 3 days 1. Exhibited on 1-2 of last 3 days	
		VERBAL EXPRESSIONS OF DISTRESS **a. PATIENT MADE NEGATIVE STATEMENTS**—(e.g., "*Nothing matters; Would rather be dead than live this way; What's the use; Let me die*") **b. PERSISTENT ANGER WITH SELF OR OTHERS**—(e.g., easily annoyed, anger at presence in post acute care, anger at care received) **c. EXPRESSIONS OF WHAT APPEAR TO BE UNREALISTIC FEARS**—(e.g., fear of being abandoned, left alone, being with others, afraid of nighttime) **d. REPETITIVE ANXIOUS COMPLAINTS/CONCERNS** (non-health related)—(e.g., persistently seeks attention/reassurance regarding therapy or others' schedules, meals, laundry, clothing, relationship issues, when family will visit) **e. REPETITIVE HEALTH COMPLAINTS**—(e.g., persistently seeks medical attention, obsessive concern with body functions, obsessive concern with vital signs) ***SAD, APATHETIC, ANXIOUS APPEARANCE*** **f. SAD, PAINED, WORRIED FACIAL EXPRESSIONS**—(e.g., furrowed brows) **g. CRYING, TEARFULNESS** **h. REPETITIVE PHYSICAL MOVEMENTS**—(e.g., pacing, hand wringing, restlessness, fidgeting, picking) ***SLEEP CYCLE ISSUES*** **i. INSOMNIA/CHANGE IN USUAL SLEEP PATTERNS** ***LOSS OF INTEREST*** **j. WITHDRAWAL FROM ACTIVITIES OF INTEREST**—(e.g., no interest in long standing activities or being with family/friends) **k. REDUCED SOCIAL INTERACTION**—(e.g., less talkative, more isolated)	
2.	MOOD PERSISTENCE (Over last 3 days)	***One or more indicators*** *of depressed, sad or anxious mood* ***were not easily altered by attempts to "cheer up," console, or reassure the patient over last 3 days*** 0. No mood indicators or always easily altered 1. Partially altered or easily altered on only some occasions 2. All aspects of mood not easily altered	
3.	BEHAVIORAL SYMPTOMS (Over last 3 days)	(***CODE*** *for behavioral symptom* ***frequency over the last 3 days***) 0. Behavior not exhibited in last 3 days 1. Behavior of this type occurred on 1 day 2. Behavior of this type occurred on 2 days 3. Behavior of this type occurred daily	
		a. WANDERING—Moved (locomotion) with no rational purpose, seemingly oblivious to needs or safety	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were threatened, screamed at, cursed at	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS—Others were hit, shoved, scratched, sexually abused	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS—Made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings	
		e. RESISTS CARE—Resisted taking medications/injections, ADL assistance, eating, or changes in position	

SECTION E. FUNCTIONAL STATUS

1.	**3 DAY ADL SELF-PERFORMANCE**—(***CODE for Performance Over All Shifts, for All Episodes, OVER LAST 3 DAYS***) [NOTE - for *Bathing and Tub Transfer*, code for most dependent single episode in this period] 0. *INDEPENDENT*—No help, setup, or supervision —OR— Help, setup, or supervision provided only 1 or 2 times during period (with any task or subtask) 1. *SETUP HELP ONLY*—Article or device provided or placed within reach of patient 3 or more times 2. *SUPERVISION*—Oversight, encouragement or cuing provided 3 or more times during period —OR— Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision) 3. *MINIMAL ASSISTANCE* (*LIMITED ASSISTANCE*)—Patient highly involved in activity; received physical help in guided maneuvering of limbs or other non-weight bearing assistance 3 or more times —OR— Combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help) 4. *MODERATE ASSISTANCE* (*EXTENSIVE ASSISTANCE*)—Patient performed part of activity on own (50% or more of subtasks) *BUT* help of following type(s) provided 3 or more times: — Weight-bearing support (e.g., holding weight of limb, trunk) — Full staff performance of a task (some of time) or discrete subtask 5. *MAXIMAL ASSISTANCE*—Patient involved but completed less than 50% of subtasks on own (includes 2+ person assist), received weight bearing help or full performance of certain subtasks 3 or more times 6. *TOTAL ASSISTANCE* (*TOTAL DEPENDENCE*)—Full staff performance of activity during entire period 8. *ACTIVITY DID NOT OCCUR*—During entire period	
		a. BED MOBILITY—How patient moves to and from lying position, turns side to side, and positions body while in bed	
		b. TRANSFER BED/CHAIR—How patient moves between surfaces—to or from: bed, chair, wheelchair, standing position (**EXCLUDE** to/from bath/toilet)	
		c. LOCOMOTION—How patient moves between locations in his/her room and adjacent corridor on the same floor. If in wheelchair, how moves once in wheelchair	
		d. WALK IN FACILITY—How patient walks in room, corridor, or other place in facility	
		e. DRESSING UPPER BODY—How patient dresses and undresses (**street clothes, underwear**) above the waist, includes prostheses, orthotics, fasteners, pullovers, etc.	
		f. DRESSING LOWER BODY—How patient dresses and undresses (**street clothes, underwear**) from the waist down, includes protheses, orthotics, belts, pants, skirts, shoes, and fasteners	
		g. EATING—How patient eats and drinks (regardless of skill), includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)	
		h. TOILET USE—How patient uses the toilet room (or commode, bedpan, urinal); cleanses self after toilet use or incontinent episode(s), changes pad, manages ostomy or catheter, adjusts clothes (**EXCLUDE** transfer toilet)	
		i. TRANSFER TOILET—How patient moves on and off toilet or commode	
		j. GROOMING/PERSONAL HYGIENE—How patient maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (**EXCLUDE** baths and showers)	
		k. BATHING—How patient takes full-body bath/shower or sponge bath (**EXCLUDE** washing of back and hair and TRANSFER). Includes how each part of body is bathed: arms, upper and lower legs, chest, abdomen, perineal area. ***Code for most dependent episode***	
		l. TRANSFER TUB/SHOWER—How patient transfers in/out of tub/shower ***Code for most dependent episode***	
2.	ADL ASSIST CODES (Code for most help in last 3 days)	0. Neither code applies 2. 2+ person physical assist 1. Weight bearing support with 1 limb **a.** Bed mobility **b.** Transfer bed/chair **c.** Locomotion **d.** Walk in facility **e.** Dressing upper body **f.** Dressing lower body **g.** Eating **h.** Toilet use **i.** Transfer **j.** Grooming/personal hygiene **k.** Bathing **l.** Transfer tub/shower	
3.	ADL CHANGES	**a.** ***NUMBER*** *of ADL areas (from* ***E1*** *above) in which patient is now more limited in self performance than was prior to precipitating event (item* ***A7a****)* **b.** ***NUMBER*** *of ADL areas (from* ***E1*** *above) in which patient was independent prior to precipitating event (item* ***A7a****)*	

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4. INSTRUMENTAL ACTIVITIES OF DAILY LIVING (In last 24 hours of 3-day assessment period)

CAPACITY TO PERFORM INSTRUMENTAL ACTIVITIES OF DAILY LIVING—if the patient had been required to carry out the activity as independently as possible, SPECULATE AND CODE for what you consider the patient's capacity (ability) would have been to perform the activity

0. *INDEPENDENT*—Would have required no help, setup, or supervision
1. *SETUP HELP ONLY*—Would have only needed article/device placed within reach; patient could have performed on own
2. *SUPERVISION*—Would have required oversight, encouragement, or cuing
3. *LIMITED ASSISTANCE*—On some occasion(s) could have done on own, other times would have required help
4. *MODERATE ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed 50% or more of subtasks on own
5. *MAXIMAL ASSISTANCE*—While patient could have been involved, would have required presence of helper at all times, and would have performed less than 50% of subtask on own
6. *TOTAL DEPENDENCE*—Full performance by other of activity would have been required at all times (no residual capacity exists)

a. **MEAL PREPARATION**—How meals are prepared (e.g., planning meals, assembling ingredients, cooking, setting out food and utensils)

b. **MANAGING FINANCES**—Paying for newspaper or TV service, using cafeteria

c. **PHONE USE**—How telephone calls are made or received (using assistive devices such as large numbers or voice amplification as needed)

d. **MEDICATION MANAGEMENT**—How medications are managed (e.g., remembering to take medicines, opening bottles, taking correct drug dosages, filling syringe, giving injections, applying ointments)

e. **STAIRS**—How moves up and down stairs (e.g., one flight of steps, using hand rails as needed)

f. **CAR TRANSFER**—How moves in and out of a car, opening door, sitting, and rising from seat

5. IADL AREAS NOW MORE LIMITED

***NUMBER** of IADL areas (from **E4** above) in which patient is now more limited in self performance than was prior to precipitating event (item **A7a**)*

0. None
1. Some (1-3 IADL areas)
2. All or most (4-6 IADL areas)

6. DEVICES/ AIDS

(***CHECK all that apply***)

LOCOMOTION DEVICES		Mechanical lift	e.
Cane/Crutch	a.	Orthotics/prosthesis	f.
Walker	b.	Postural support (while sitting)	g.
Wheelchair/scooter	c.	Slide board	h.
OTHER AIDS		Other adaptive devices	i.
Adaptive eating utensil	d.	*NONE OF ABOVE*	j.

7. STAMINA

CODE:
0. None
1. Less than 1 hour per day
2. 1 to 2 hours per day
3. 2+ to 3 hours per day
4. 3+ to 4 hours per day
5. More then 4 hours per day

	A Last 24 hours	B Prior
Hours of physical activity at two points in time—examples of physical activity include exercise, therapy sessions, walking, house cleaning, grocery shopping **(A) *in last 24 hours*** *and* **(B) *immediately prior*** *to precipitating event (item **A7a**)*		

8. WALKING AND STAIR CLIMBING (Note time frame)

a. Farthest distance walked without sitting down **Code for most consistent in last 24 hours**
0. 150+ feet
1. 51-149 feet
2. 25-50 feet
3. 10-24 feet
4. Less than 10 feet
8. *ACTIVITY DID NOT OCCUR*

b. Walking support provided **Code for most consistent in last 24 hours**
0. None
1. Setup help only
2. Supervision
3. One person physical assistance
4. Two+ person physical assistance
8. *ACTIVITY DID NOT OCCUR*

8. WALKING AND STAIR CLIMBING (Note time frame) (cont)

c. **Stair climbing—Code for most dependent episode when activity attempted in last 24 hours** [full flight = 12-14 stairs; partial flight = 4-6 stairs] *There are only three possible codes when patient does 4-6 stairs only (code = 2,5,6)*

0. *COMPLETE INDEPENDENCE*—Up and down **full** flight of stairs with NEITHER *physical help* NOR *support device*
1. *MODIFIED INDEPENDENCE*—Up and down **full** flight of stairs with NO *physical help and any of following:*
Use of one or more supportive devices [*support devices* includes the **required** use of hand rails]
OR Use of an appliance (i.e., cane, brace, prosthesis, walker)
OR Excessive time to climb the stairs (3 or more times normal)
2. *SUPERVISION*—Up/down **full** flight of stairs with supervision or cuing -OR- up and down partial flight with NO physical help (device may or may not be used)
3. *MINIMAL ASSISTANCE*—Contact guard/steadying/assistance to go up/down **full** flight of stairs
4. *MODERATE ASSISTANCE*—Some weight bearing help to go up/down **full** flight of stairs, patient does most on own
5. *MAXIMAL ASSISTANCE*—Patient had limited involvement in going up/down full flight of stairs, staff perform more than 50% of effort -OR- receives physical help on partial flight of stairs
6. *TOTAL ASSISTANCE*—Did not go up/down 4-6 stairs (OR has 2-person assist) OR totally dependent
8. *ACTIVITY DID NOT OCCUR **IN LAST 24 HOURS***

9. BALANCE RELATED TO TRANSITIONS (Code for most dependent in last 24 hours)

CODE:
0. Smooth transition; stabilizes without assistance
1. Transition not smooth, but able to stabilize without assistance
2. Transition not smooth; unable to stabilize without assistance
8. *ACTIVITY DID NOT OCCUR*

a. Moved from seated to standing position

b. Turned around and faced the opposite direction

10. NEURO-MUSCULO-SKELETAL IMPAIRMENT (Code for most limited in last 24 hours)

A. (***CODE** for joint mobility/range of motion at joints listed* **(*code for most impaired joint*)**)
0. No impairment
1. Impairment on one side
2. Impairment on both sides

B. (***CODE** for voluntary motor control (active, coordinated, purposeful movement - **code for most dependent joint***)**)
0. No loss
1. Partial loss one side
2. Partial loss both sides
3. Full loss one side
4. Full loss both sides

C. (***CODE** for Intact touch/sensation on extremity, i.e., tactile sense* **(use same codes as E10B)**)

	A	B	C
a. Leg (hip, knee, ankle, foot)			
b. Arm (shoulder, elbow, wrist, hand)			
c. Trunk and neck			

SECTION F. BLADDER/BOWEL MANAGEMENT

1. BLADDER CONTINENCE (Code for last 7-14 days)

a. *Control of urinary bladder function (if dribbles, volume insufficient to soak through undergarments)*

0. *CONTINENT*—Complete control; DOES NOT USE any type of catheter or other urinary collection device
1. *CONTINENT WITH CATHETER*—Complete control with use of any type of catheter or urinary collection device that does not leak urine
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—Incontinent episodes 2 or more times a week but not daily
5. *FREQUENTLY INCONTINENT*—Tended to be incontinent daily, but some control present (i.e., on day shift)
6. *INCONTINENT*—Has inadequate control of bladder, multiple daily episodes all or almost all of time
8. *DID NOT OCCUR*—No urine output from bladder

b. *Is now more impaired in bladder continence than was prior to precipitating event (item **A7a**)*
0. No or unsure
1. Yes, more impaired today

2. BLADDER APPLIANCE (Code for last 24 hours)

CODE:
0. No
1. Yes

a. External catheter		e. Ostomy	
b. Indwelling catheter		f. Pads, briefs	
c. Intermittent catheterization		g. Urinal, bedpan	
d. Medications for control			

3. BLADDER APPLIANCE SUPPORT (Code for last 24 hours)

0. No appliances **(in item F2)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of sub-tasks involved in using equipment
5. Maximal assistance; patient able to do 25-49% of all sub-tasks involved in using the equipment
6. Total dependence

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4. BOWEL CONTINENCE (Code for last 7-14 days)
0. *CONTINENT*— Complete control, does not use ostomy device
1. *CONTINENT WITH OSTOMY*—Complete control with use of an ostomy device that does not leak stool
2. *BIWEEKLY INCONTINENCE*—Incontinent episodes less than once a week (i.e., once in last 2 weeks)
3. *WEEKLY INCONTINENCE*—Incontinent episodes once a week
4. *OCCASIONALLY INCONTINENT*—2-3 times a week
5. *FREQUENTLY INCONTINENT*—4+ times a week but not all of time
6. *INCONTINENT*—All of time
8. *DID NOT OCCUR*— No bowel movement during the entire 14 day assessment period

5. BOWEL APPLIANCES (Code for last 3 days)
CODE: 0. No 1. Yes
a. Bedpan
b. Enema
c. Medication for control
d. Ostomy

6. BOWEL APPLIANCE SUPPORT (Code for last 24 hours)
0. No appliances **(in item F5)**
1. Use of appliances, did not require help or supervision
2. Use of appliances, required supervision or setup
3. Minimal contact assistance (light touch only)
4. Moderate assistance; patient able to do 50% or more of tasks
5. Maximal assistance; patient able to do 25-49% of all sub-tasks
6. Total dependence

SECTION G. DIAGNOSES

1. IMPAIRMENT GROUP *Refer to manual for coding of impairment group*

2. OTHER DISEASES
CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
[If no disease in list, check **G2aq *None of Above*** item]

ENDOCRINE
a. Diabetes mellitus (250.00)
b. Hypothyroidism (244.9)
HEART/CIRCULATION
c. Cardiac arrythmias (427.9)
d. Congestive heart failure (428.0)
e. Coronary artery disease (746.85)
f. Deep vein thrombosis (451.1)
g. Hypertension (401.9)
h. Hypotension (458.9)
i. Peripheral vascular disease (arteries) (443.9)
j. Post acute MI (within 30 days) (410.92)
k. Post heart surgery (e.g., valve, CABG) (V45.81)
l. Pulmonary embolism (415.1)
m. Pulmonary failure (518.8)
n. Other cardiovascular disease (429.2)
MUSCULOSKELETAL
o. Fracture - hip (V43.64)
p. Fracture - lower extremity (812.40)
q. Fracture(s) - other (829.0)
r. Osteoarthritis (715.90)
s. Osteoporosis (733.00)
t. Rheumatoid arthritis (714.0)
NEUROLOGICAL
u. Alzheimer's disease (331.0)
v. Aphasia or Apraxia (784.3,784.69)
w. Cerebral palsy (343.9)
x. Dementia other than Alzheimer's disease (290.0)
y. Hemiplegia/hemiparesis — left side (342.90)
z. Hemiplegia/hemiparesis — right side (342.90)
aa. Multiple sclerosis (340)
ab. Parkinson's disease (332.0)
ac. Quadriplegia (344.00 - 344.09)
ad. Seizure disorder (780.39)
ae. Spinal cord dysfunction—non-traumatic (336.9)
af. Spinal cord dysfunction—traumatic (952.9)
ag. Stroke (CVA) (436)
PSYCHIATRIC/MOOD
ah. Anxiety disorder (300.00)
ai. Depression (311)
aj. Other psychiatric disorder (300.9)
PULMONARY
ak. Asthma (493.9)
al. COPD (496)
am. Emphysema (492.8)
OTHER
an. Cancer (199.1)
ao. Post surgery - non-orthopedic, non-cardiac (V90.9)
ap. Renal failure (586)
aq. *NONE OF ABOVE*

3. INFECTIONS
CODE:
[Blank] Not present
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment
(If no infections, check *NONE OF ABOVE item G3l*)

a. Antibiotic resistant infection (e.g., methicillin resistant staph - (041.11), VRE - (041.9))
b. Cellulitis (682.9)
c. Hepatitis (070.9)
d. HIV/AIDS (042)
e. Pneumonia (486)
f. Osteomyelitis (730.2)
g. Septicemia (038.9)
h. Staphylococcus infection (other than item "G3a") (041.10)
i. Tuberculosis (active) (011.90)
j. Urinary tract infection (599.0)
k. Wound infection (958.3, 998.59,136.9)
l. *NONE OF ABOVE*

4. OTHER CURRENT OR MORE DETAILED DIAGNOSES AND ICD-9-CM CODES (Any new diagnosis at reassessment or discharge is to be recorded here)
A. ***CODE ICD-9-CM diagnosis code***
B. ***CODE***:
1. Other primary diagnosis/diagnoses for current stay (not primary impairment)
2. Diagnosis present, receiving active treatment
3. Diagnosis present, monitored but no active treatment

	A. ICD-9-CM	B
a.		
b.		
c.		
d.		
e.		

5. COMPLICATIONS/COMORBIDITIES *Code the **ICD-9-CM** diagnostic code. Refer to manual to code comorbidities.*

DIAGNOSIS	ICD-9-CM
a.	
b.	
c.	
d.	

SECTION H. MEDICAL COMPLEXITIES

1. VITAL SIGNS *Vital signs (pulse, BP, respiratory rate, temperature)* ***Score for the most abnormal vital sign***
0. All vital signs were normal/standard (i.e., when compared to standard values)
1. Vital signs abnormal, but not on all days during assessment period
2. Vital signs consistently abnormal (on all days)

2. PROBLEM CONDITIONS (In last 3 days)
(***CHECK** all problems present in the **last 3 days** unless otherwise noted*)
FALLS/BALANCE
Dizziness/vertigo/light-headedness a.
Fell (since admission or last assessment) b.
Fell in **180 days** prior to admission c.
CARDIAC/PULMONARY
Advanced cardiac failure (ejection fraction < 25%) d.
Chest pain/pressure on exertion e.
Chest pain/pressure at rest f.
Edema - generalized g.
Edema - localized h.
Edema - pitting i.
Impaired aerobic capacity/endurance (tires easily, poor task endurance) j.
FLUID STATUS
Constipation k.
Dehydrated; output exceeds input; or BUN/Creat ratio > 25 l.
Diarrhea m.
Internal bleeding n.
Recurrent nausea/vomiting o.
Refusal/inability to take liquids orally p.
OTHER
Delusions/hallucinations q.
Fever r.
Hemi-neglect (inattention to one side) s.
Cachexia (severe malnutrition) t.
Morbid obesity u.
End-stage disease, life expectancy of **6 or fewer months** v.
NONE OF ABOVE w.

3. RESPIRATORY CONDITIONS (In last 3 days)
(***CHECK** all problems present in the **last 3 days***)
Inability to lie flat due to shortness of breath a.
Shortness of breath with exertion (e.g., taking a bath) b.
Shortness of breath at rest c.
Oxygen saturation < 90% d.
Difficulty coughing and clearing airway secretions e.
Recurrent aspiration f.
Recurrent respiratory infection g.
NONE OF ABOVE h.

4. PRESSURE ULCERS (Code for last 24 hours)
a. *Highest current pressure ulcer stage*
0. No pressure ulcer **(if no, skip to H5)**
1. Any area of persistent skin redness **(Stage 1)**
2. Partial loss of skin layers **(Stage 2)**
3. Deep craters in the skin **(Stage 3)**
4. Breaks in skin exposing muscle or bone **(Stage 4)**
5. Not stageable (necrotic eschar predominant; no prior staging available)

b. *Number of current pressure ulcers*

SELECT THE CURRENT LARGEST PRESSURE ULCER TO CODE THE FOLLOWING—calculate three components (**c** through **e**) and code total score in **f**

c. Length multiplied by width (open wound surface area)
0. 0 cm^2
1. <0.3 cm^2
2. 0.3–0.6 cm^2
3. 0.7–1.0 cm^2
4. 1.1–2.0 cm^2
5. 2.1–3.0 cm^2
6. 3.1–4.0 cm^2
7. 4.1–8.0 cm^2
8. 8.1–12.0 cm^2
9. 12.1–24.0 cm^2
10. > 24 cm^2

d. Exudate amount
0. None 1. Light 2. Moderate 3. Heavy

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4.	**PRESSURE ULCERS** (Code for last 24 hours) (cont)	**e.** Tissue type 0. Closed/resurfaced: The wound is completely covered with epithelium (new skin) 1. Epithelial tissue: For superficial ulcers, new pink or shiny tissue (skin) that grows in from the edges or as islands on the ulcer surface 2. Granulation tissue: Pink or beefy red tissue with a shiny, moist, granular appearance 3. Slough: Yellow or white tissue that adheres to the ulcer bed in strings or thick clumps or is mucinous 4. Necrotic tissue (eschar): Black, brown, or tan tissue that adheres firmly to the wound bed or ulcer edges	
		f. TOTAL PUSH SCORE (sum of above three items—**c**, **d**, and **e**)	
5.	**OTHER SKIN INTEGRITY**	**a.** Number of stasis ulcers **in last 24 hours**	
		b. Number of surgical wounds **in last 24 hours**	
		c. Ulcer resolved or healed **in last 90 days** 0. No or never had ulcer 1. Yes	
6.	**OTHER SKIN PROBLEMS OR LESIONS PRESENT** (Code for last 24 hours)	(***CHECK all that apply***)	
		Burns (second or third degree)	a.
		Open lesions other than rashes, cuts (e.g., cancer lesions, ulcers)	b.
		Rashes (e.g., intertrigo, eczema, drug rash, heat rash, herpes zoster)	c.
		Skin tears or cuts (other than surgery)	d.
		NONE OF ABOVE	e.

SECTION I. PAIN STATUS

1.	**PAIN SYMPTOMS** (In last 3 days)	(***CODE the highest level of pain present in the last 3 days, even with treatments*** [Note - At minimum, patient must be asked about frequency and intensity])	
		a. FREQUENCY with which patient complains or shows evidence of pain 0. No pain 2. Daily - single shift 1. Less than daily 3. Daily - multiple shifts	
		b. INTENSITY of pain 0. No pain 2. Moderate 4. Times when pain is horrible 1. Mild 3. Severe or excruciating	
		c. Current pain status as compared to pain status prior to precipitating event (item **A7a**) 0. Same 1. Better 2. Worse 8. UNKNOWN	

SECTION J. ORAL/NUTRITIONAL STATUS (In last 3 days)

1.	**ORAL PROBLEMS**	***CODE***: 0. No 1. Yes	
		a. Chewing problem (e.g., poor mastication, immobile jaw, surgical resection, decreased sensation/motor control)	
		b. Dental problems (e.g., ill-fitting or lack of dentures, painful tooth, poor dental hygiene)	
2.	**SWALLOWING**	0. *NORMAL*—Safe and efficient swallowing of all diet consistencies 1. *REQUIRES DIET MODIFICATION TO SWALLOW SOLID FOODS* (mechanical diet or able to ingest specific foods only) 2. *REQUIRES MODIFICATION TO SWALLOW SOLID FOODS AND LIQUIDS* (puree, thickened liquids) 3. *COMBINED ORAL AND TUBE FEEDING* 4. *NO ORAL INTAKE (NPO)*	
3.	**HEIGHT AND WEIGHT**	*Record* ***(a.) height in inches*** *and* ***(b.) weight in pounds****. Base weight on most recent measure in* ***last 3 days****; measure weight consistently in accordance with standard facility practice—e.g., in a.m. after voiding, before meal, with shoes off, and in nightclothes* **a.** HT (inches) **b.** WT (pounds)	
4.	**WEIGHT CHANGE**	**a. Weight loss**—5 % or more in **last 30 days** 0. No or unknown 1. Yes, planned loss 2. Yes, unplanned loss	
		b. Weight gain—5 % or more in **last 30 days** 0. No or unknown 1. Yes, planned gain 2. Yes, unplanned gain	
5.	**PARENTERAL OR ENTERAL INTAKE**	**a.** The proportion of **total calories** the patient received through parenteral or tube feedings in the **last 3 days** 0. None 3. 51% to 75% 1. 1% to 25% 4. 76% to 100% 2. 26% to 50%	
		b. The average **fluid intake** per day by IV or tube in **last 3 days** 0. None 3. 1001 to 1500 cc/day 1. to 500 cc/day 4. 1501 to 2000 cc/day 2. 501 to 1000 cc/day 5. 2001 or more cc/day	

SECTION K. PROCEDURES/SERVICES (In last 3 days)

1.	**CLINICAL VISITS AND ORDERS**	*Services in* ***last 3 days***	
		a. Total number of physician visits (by attending, consultant, etc.) in which patient was examined and MD notes written	
		b. Number of times **physician or nurse practitioner** called to bedside for emergency—e.g., cardiorespiratory arrest, hemorrhaging, to evaluate change in condition	
		c. Number of **nurse practitioner** visits in which patient examined and notes written	
		d. Number of **physician assistant** visits in which patient examined and notes written	
		e. Number of **new or changed orders**	

2.	**TREATMENTS AND SERVICES**	**A. Over the last 3 days**, code for *treatment frequency* [*either daily* (*code 3*) *or less than daily* (*code 2*) or ordered, not yet implemented (code 1)] **(If no treatments provided or ordered, check *NONE OF ABOVE item K2ai*)** [*Blank*] Did not occur, not ordered 2. Less than daily 1. Ordered, not yet implemented 3. Daily **B.** ***RECORD AT DISCHARGE ASSESSMENT ONLY*** **(A3 = 5)**, *record whether patient will receive service after discharge* [*Blank*] No 1. Yes					
			A	**B**		**A**	**B**
		MEDICATION RELATED			r. Drains (cutaneous drains and other drains)		
		a. Diabetic management			s. Dialysis		
		b. Injections			t. Enteral feeding tube		
		c. IV antibiotics/meds			u. IV line - central		
		SKIN TREATMENT			v. IV line - peripheral		
		d. Application of dressings			w. NG feeding tube		
		e. Application of ointments, topical medications			x. Oxygen		
		f. Debridement (chemical or surgical)			y. Pain management - other than drugs		
		g. Nutrition/hydration intervention to manage skin problems			z. Suctioning - oral/nasopharyngeal		
		h. Pressure relieving bed/chair			aa. Suctioning - tracheal		
		i. Turning and repositioning			ab. Tracheostomy care		
		j. Ulcer care			ac. Transfusion(s)		
		k. Wound care - surgical			ad. Ventilator or respirator		
		MANAGEMENT OF HEALTH PROBLEMS			ae. Ventilator weaning		
		l. Bladder training			**OTHER**		
		m. Scheduled toileting			af. Family training in assistance to patient in health measures or skills required after return to community		
		n. Bowel program			ag. Patient training in health maintenance or skills required after return to community		
		o. Cardiac monitoring/rehabilitation			ah. Design and implementation of discharge plan		
		p. Cast(s)					
		q. Continuous or bi-level positive airway pressure (CPAP or BiPAP)			ai. *NONE OF ABOVE*	ai.	ai.
3.	**NURSING PRACTICE OR RESTORATIVE CARE**	*Record the NUMBER OF DAYS each of the following restorative or practice techniques was* ***provided to the patient for more than or equal to a total of at least 15 minutes per day in the last 3 days*** *(Enter 0 if none or less than 15 min. daily)*					
		a. Range of motion (passive)			f. Transfer		
		b. Range of motion (active)			g. Walking		
		c. Splint/orthotic assistance			h. Dressing or grooming		
		TRAINING AND SKILL PRACTICE IN			i. Eating or swallowing		
		d. Bed mobility			j. Amputation/prosthesis care		
		e. Bladder/bowel			k. Communication		
4.	**THERAPY SERVICES** (By qualified therapist or therapy assistant under direction of therapist)	*Over the* ***last 3 days****, record the number of days and total minutes each of the following therapies was ordered* **[A]** *administered* **[B]** *(for at least 15 minutes a day) (Enter 0 if none or less than 15 min. daily)* **[Note—count only post admission therapies]** **A. # of days** treatment ordered during the **last 3 days [MAX=3]** **B. # of days** administered for **15 minutes or more [MAX=3]** **C. total # of minutes** provided in **last 3 days** (or *ordered* if days administered = 0 and days ordered > 0)					
		D. ***RECORD AT DISCHARGE ASSESSMENT*** ***(A3 = 5)****, record whether patient will receive service after discharge* 0. No 1. Yes	**DAYS Ordered**	**DAYS Administered**	**Minutes Delivered**		**Post Discharge**
			A	**B**	**C**		**D**
		a. Speech - language pathology and audiology services					
		b. Occupational therapy					
		c. Physical therapy					
		d. Respiratory therapy					
		e. Psychological therapy (by any licensed mental health professional)					
		f. Therapeutic recreation					